Mental Health Advisory Team-Korea (8th Army)

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The results and opinions presented in this report are those of the Mental Health Advisory Team-Korea (8th Army) members and do not necessarily represent official policy or position of the Department of Defense.

MHAT-K8A members would like to acknowledge the active involvement and support provided by 8th Army and USFK Surgeon's Cells as well as MHAT-K8A Liaison Officers and Army Behavioral Health personnel across Korea. The MHAT-K8A team also wishes to recognize Regional Health Command-Pacific and the Office of the Surgeon General subject matter experts whose guidance and collaboration on this report were greatly valued.

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1 EXECUTIVE SUMMARY

1.1 Introduction

The Mental Health Advisory Team-Korea (8th Army) (referred to as MHAT-K8A elsewhere in this report) mission to Korea was requested by the Deputy Chief of Staff for US Forces-Korea (USFK) and coordinated with the USFK and 8th Army Surgeons and the 121st Combat Support Hospital. MHAT-K8A was the first assessment ever conducted in Korea or in the Pacific Command (PACOM). As in previous iterations of MHATs, (OIF, OEF) behavioral health researchers from the US Army Medical Research and Material Command (MRMC) took the lead in mission execution with key strategic support and guidance provided by USFK, 8th Army, Regional Health Command-Pacific (RHC-P), and the Office of the Surgeon General (OTSG).

Through discussions with the USFK Surgeon, MHAT-K8A was asked to conduct a comprehensive assessment examining the behavioral health (BH) burden among USFK personnel in Korea with a focus on staffing and access to care challenges as well as factors that positively and negatively affect the behavioral health environment for Service Members and Families. Specific focal areas for the assessment included behavioral health risk factors, protective factors, and clinical prevalence estimates for common behavioral health problem areas such as suicidal ideation, PTSD, depression, and anxiety. MHAT-K8A team members also conducted special data calls to examine suicide and behavioral health staffing specifically. After conducting the initial assessment with 8th Army units, the team provided recommendations to sustain and improve the behavioral health of Soldiers and units.

From November 2015 to January 2016, the MHAT-K8A advanced party coordinated with USFK and 8th Army staff and medical leaders in order to develop a cluster-based sampling plan to distribute surveys and conduct focus groups. Platoons were randomly selected from all 8th Army major subordinate command units to complete the anonymous MHAT-K8A survey. Surveys from 1,613 Soldiers from 66 platoons were returned and all met the sampling plan criteria. Surveys from 54 of the 79 behavioral health staff assigned to Korea were returned. Fourteen focus groups were conducted with Soldiers (n = 87) and four focus groups were conducted with Behavioral Health Providers (n = 19).

From 17 January to 30 June 2016, MHAT-K8A team members (a) processed and analyzed survey data, (b) conducted focus group interviews with Soldiers, (c) conducted interviews with key behavioral health personnel, (d) briefed key regional stakeholders on initial findings and (3) wrote the technical report in consultation with USFK, RHC-P, and OTSG.

This report describes findings from units and Soldiers assigned to 8th Army units only. In general, the prevalence of behavioral health problems was found to be lower than other MHAT comparisons. Nonetheless, key risk factors associated with behavioral health problems were identified and recommendations were made for sustainment or improvement. A follow-on data collection with other USFK units (remaining Army, Air Force, Navy, and Marines) is planned for the fall of 2016 and will complete the assessment for USFK. Once the follow-on data collection is complete, this report will be amended to include an appendix with results from the assessment with other USFK units.

Data collected in the MHAT-K8A report benchmarks findings against comparable datasets from: (1) previous MHAT combat datasets (Operation Enduring Freedom (OEF) 2012, OEF 2013), and (2) census samples from a brigade stationed overseas in US Army, Europe (USAREUR 2015) and Army elements of a Combined Joint Task Force deployed to the Horn of Africa (Combined Joint Task Force (CJTF)-HOA 2012).

The report contains six key sections of results based on survey and focus group data, data provided by Regional Health Command-Pacific, and secondary data sources: (1) behavioral health indices, (2) risk

factors, (3) protective factors, (4) behavioral health staffing, (5) focus group summaries, and (6) integrated recommendations.

1.2 Key Findings

1.2.1 *Behavioral Health Status*

1. Suicide: There were five Army suicides in Korea in 2015 compared to one in 2014, and three in both 2013 and 2012 (data provided by Defense Suicide Prevention Office). While the Army count for 2015 was at its highest in four years, the rate increase was only marginally significant (p = .10) compared to the previous four years in Korea; the Army rate in Korea was not significantly higher than the Army as whole using the criteria and parameters laid out by Bliese, Adler, Wright, and Hoge (2007).

2. Suicidal Ideation: The prevalence estimate of suicidal ideation or self-harm was 8%. While the rate of ideation was similar to rates reported in other studies, the greatest risk was associated with social isolation, sleep problems, relationship problems, and financial problems.

3. Psychological Problems: Prevalence estimates of Soldiers meeting criteria for any psychological problem (PTSD, depression, or anxiety) were significantly lower than MHAT data collected in the Horn of Africa and Afghanistan in 2012, and similar to estimates in a USAREUR brigade in 2015 and Afghanistan in 2013.

4. Sleep Problems: Twenty-two percent of 8th Army Soldiers met screening criteria for moderate to severe insomnia; this is comparable to other Army studies where insomnia has been assessed using the same survey instrument. 8th Army Soldiers also reported an average of 5.6 hours of sleep per night, and this amount was significantly more sleep than reported in other comparison studies, however, it is still less than the 7-8 hours recommended by the Army Surgeon General's performance triad and the Centers for Disease Control and Prevention.

5. Alcohol Problems: Twenty-eight percent of 8th Army Soldiers were estimated to have met the screening criteria for alcohol misuse. This percentage was significantly lower than estimates from USAREUR in 2015 and higher than estimates from the MHAT data from the CJTF-HOA. It is important to note alcohol misuse was not assessed during OEF 2012 and 2013; and alcohol was available but restricted in the CJTF-HOA in 2012.

1.2.2 *Risk Factors*

1. Social Isolation: About one-third of 8th Army Soldiers reported feeling socially isolated, a risk factor associated with physical and psychological morbidity. Social isolation was the greatest identified risk factor for suicidal ideation and was also significantly related to anxiety, depression, PTSD, and alcohol misuse.

2. Discipline and Financial Problems: Discipline problems ranged from 6-17% and seven percent of Soldiers reported having serious financial difficulties. Both discipline and financial problems were strongly predictive of alcohol misuse and other behavioral health problems.

3. Sexual Harassment/Assault: Estimated prevalence of sexual harassment and assault were comparable to estimates reported in other DOD population-based studies with women reporting higher rates of both sexual harassment and assault than men. If respondents reported they

observed sexual harassment, 92% of these respondents reported that they intervened in some way.

4. Korea Tour Stressors: The most frequently endorsed tour stressors for 8th Army Soldiers in Korea included poor sleeping conditions, lack of privacy, and family separation. Poor barracks living conditions were noted during Soldier focus groups.

1.2.3 *Protective Factors*

1. Leadership: More than 70% of 8th Army Soldiers rated both platoon leader and platoon sergeant as high in general leadership. Soldiers who reported that their unit leaders engaged in pro-behavioral health leadership behaviors such as following operational stress control principles reported less stigma and fewer barriers to care.

2. Unit Cohesion and Readiness: Nearly 60% rated their unit cohesion and readiness as high. This percentage was lower than in previous combat MHATs in Afghanistan. The difference between ratings in Korea and Afghanistan are not that surprising since it is reasonable to assume that a combat-deployed unit's readiness and cohesion would be expected to be higher given the environment, the nature of the mission, and the shared experiences among unit members.

3. Morale: Unit morale was rated significantly higher than in all other comparison studies; and individual morale was higher than in the Horn of Africa and Afghanistan in 2012 and 2013 than in the MHAT-K8A survey.

4. Relationship Problems: Marital quality estimates were comparable to other MHAT studies. Similarly, problems with infidelity (12%) and planning for a divorce (13%) were comparable to estimates from other MHAT studies. Relationship problems were predictive of suicidal ideation.

5. Stigma and Barriers to Receiving Behavioral Healthcare: Both stigma and barriers to care were significantly lower in Korea than in other MHAT comparison studies. As has been found across a range of other studies, Soldiers who screened positive for a behavioral health problem were two to three times more likely to report stigma or barriers to care problems than those who screened negative.

1.2.4 *Key Finding from Behavioral Healthcare System Assessment*

1. Behavioral Health Utilization: Twenty-three percent of 8th Army Soldiers reported seeking behavioral health support. The most frequent sources of support that Soldiers accessed were from behavioral health providers, medical doctors, chaplains, and other unit members. Junior-enlisted Soldiers were the most frequent users of behavioral health comprising 77% of behavioral health admissions, and around two-thirds of patient encounters (data provided by 121st Combat Support Hospital).

2. Telebehavioral Health (TBH): Eleven (11) of the fifty-four (54) behavioral health staff reported using telebehavioral health. Of the eleven who used telebehavioral health, eight felt it was efficient and were comfortable discussing Soldier issues. In focus groups, providers generally agreed telebehavioral health was a valuable, but underutilized, resource. In RHC-P's assessment of telebehavioral health utilization, they also reported that it was underutilized, appointments were frequently cancelled, and there were technical difficulties with TBH calls.

3. Behavioral Health Staffing: At the time of the assessment, there were [redacted] behavioral health Providers in Korea. The Behavioral Health Service Line (BHSL) distribution Matrix tool modeled the need in Korea for [redacted] behavioral health Providers. Thus, [redacted] yielded a staffing fill rate of [redacted]. The [redacted] fill rate percentage was consistent with percentages reported to the MHAT-K8A team at the enterprise level across AMEDD.

4. MHAT-K8A behavioral health staff survey and focus group results: Survey and focus group data from providers revealed the perception of inadequate staffing was common and that personnel turnover negatively affected the clinic's ability to perform its mission. Backfill support provided by other AMEDD medical centers was valued by Korea-based behavioral health staff when encountered. With regard to a specific staffing concern, providers in focus groups all mentioned that the Army Substance Abuse Program, an important program for Soldiers, faced staffing challenges due to a history of ASAP provider staff leaving the position for other opportunities at a higher pay grade in other behavioral healthcare domains in Korea.

5. Integrated MHAT-K8A and RHC-P behavioral health staffing findings: Based on data collected from RHC-P and MHAT-K8A some general areas for improvement were noted. These included: (1) ensuring Capacity Assessment Reporting Tool (CART) data is timely and accurate; (2) ensuring behavioral health personnel are fully aligned with the BHSL distribution Matrix staffing tool; (3) emphasizing filling and maintaining contract support as well as DA civilian support; (4) the need for 68Xs to be more fully utilized clinically instead of providing the bulk of administrative support to the clinics due to shortages in front-office staff; (5) the need for Behavioral Health Officers' clinical time to be fully captured with current MEDCOM metrics; and (6) shorter tours (compared to typical CONUS-based assignments) for Soldiers and providers makes therapeutic engagement and continuity of care a challenge for providers and beneficiaries in Korea.

1.2.5 *Recommendations*

1. Optimizing Behavioral Health Staffing (Proponents: OTSG, MEDCOM)

    a. Ensure that medical treatment facility personnel optimize data input for the Capacity Assessment Reporting Tool (CART) and the Behavioral Health Service Line Matrix staff and productivity measurement.

    b. Continue backfill support to clinics in Korea; pursue and leverage other support opportunities.

    c. Fully utilize telebehavioral health capability.

    d. Fully utilize clinic staff to serve as mission enablers: 68X, Administrative Support.

    e. Ensure the Behavioral Health Officer (BHO) positions in the Brigades are fully staffed and clinical duties are routinely and continually documented.

    f. Adjust Army Substance Abuse Program Counselor paygrade level.

2. Identifying and Supporting At-Risk Groups (Proponents: 8th Army, TRADOC, G1)

    a. Ensure behavioral health prevention and outreach efforts for all in-bound personnel occur soon after arriving in Korea: focus on junior enlisted and new accessions throughout Korea.

    b. Focus on Soldiers with the following key risk factors: social isolation, financial difficulties, recent relationship problems, and recent UCMJ actions.

3. Optimizing Behavioral Health in Units (Proponents: 8th Army, IMCOM)

    a. Emphasize social and team-building activities during off-duty time and especially over holidays to combat social isolation and subsequent effects on behavioral health.

    b. Review sponsorship programs for in-bound personnel.

2 BACKGROUND

2.1 Mission and Background

MHAT-K8A is the 14th MHAT to be conducted since 2003. The Walter Reed Army Institute of Research maintains the MHAT capability and has led and been the research component of all 14 MHAT missions. From 2003-2009, six MHATs were conducted during combat operations in Iraq. From 2005-2013, six MHATs were conducted during combat operations in Afghanistan. In 2012, an MHAT was conducted during peacekeeping operations in the Horn of Africa. MHAT-K8A is the first regionally-focused MHAT to be conducted and is in support of Soldiers stationed in Korea where the US Army has maintained a presence since 1950.

As with previous MHATs, the MHAT-K8A mission was threefold: 1) provide theater-wide assessment of behavioral health status of Soldiers across the 8th Army major subordinate commands, 2) assess behavioral health staffing support, and 3) provide recommendations to sustain and optimize unit behavioral health. The MHAT-K8A team conducted the assessment in Korea from 17 January to 29 February 2016. This report presents MHAT-K8A findings from anonymous surveys and focus groups conducted with Soldiers and behavioral health staff across 8th Army's major subordinate commands and the four regional areas where US Forces are located in Korea. The report also includes secondary data provided to address specific data inquiries (e.g., behavioral health staffing and suicide). MHAT-K8A members were supported by US Forces Korea and 8th Army Surgeon cells in conducting the mission.

2.2 Sampling Strategy

The MHAT-K8A report is based upon multiple sources of information as noted above. The core of the report centers on quantitative data from anonymous surveys completed by Soldiers. We obtained a representative sample of Soldiers by using cluster-based sampling of two platoons from each Battalion-sized element in each of 8th Army's major subordinate commands. A similar sampling strategy was first used in the MHAT missions conducted in 2009 [MHAT 6: OIF and MHAT 6: OEF] and has been used in all subsequent MHAT missions (see Bliese, Thomas, McGurk, McBride, & Castro, 2011), with the exception of the Horn of Africa which surveyed the entire population. For MHAT-K8A, we sampled from maneuver and support and sustainment units throughout Korea as well as an additional unit on a rotational deployment. The complexity of the organizational structure and dispersion in Korea made the cluster-based based sampling approach challenging and time-intensive. MHAT-K8A worked closely with the 8th Army Surgeon cell to ensure representativeness, and also worked with liaison officers from each of the Battalions sampled in order to ensure the sampling plan was followed. Any deviations from the a priori sampling plan were discussed and decisions made from logical substitution rules and best fit/approximation for a given unit.

2.2.1 Advantages of a cluster-based sampling strategy

1. Executing a sampling plan is feasible by pairing the plan with the common way any operation is implemented in Army units: through Operation Orders, Task Orders, and Fragmentary Orders from the operational level (8th Army) down to the tactical level (e.g., platoon). Nesting the sampling plan with orders enables the identification of specific units for participation and the identification of organic medical personnel assigned to each unit (Battalion) to administer and collect project materials and liaise with MHAT personnel.

2. The use of cluster-based sampling provides some degree of anonymity to Soldiers. As noted in the MHAT 6 OEF report (Mental Health Advisory Team 6, 2009), the anonymity is less than that offered in earlier MHAT missions (2003-2008); however, it is substantially greater than a sampling approach that

identifies specific Soldiers based on individual demographic characteristics. To be clear, while a platoon may be tasked with completing the survey there is no information collected that could identify an individual participant in that platoon.

3. The sampling strategy selects respondents at the platoon level from Battalions from all major subordinate commands under 8th Army. This minimizes the possibility of drawing a biased sample and ensures representativeness across all of 8th Army. Since maneuver units are generally interchangeable (at a conceptual level at least), the cluster-based sampling plan provides a convenient way to generate a representative sample. As noted above, however, this is the first MHAT that has implemented the sampling approach with not only maneuver units but also support units which comprise a large and critical component of 8th Army units in Korea. The MHAT-K8A team worked closely with all support units identified at the Battalion level to select appropriate and representative units to make up this important part of the MHAT-K8A sample.

2.2.2 Other Considerations

1. While maneuver unit platoons have comprised the core component of MHATs conducted in Iraq and Afghanistan, the MHAT Horn of Africa data were collected using a census-based approach as was the USAREUR-based brigade. Data from both of these studies are used as comparison datasets here. While we recognize the difference in methodological approaches as a limitation, we believe that because over 50% of all available Soldiers from each study population participated (USAREUR and CJTF-HOA), the data are representative and generalizable, and are therefore appropriate comparison studies for MHAT-K8A.

2. MHATs from 2009-2013 in Iraq and Afghanistan only utilized maneuver platoons. As noted above, MHAT-K8A utilized both maneuver and support units as part of the sampling strategy. Consequently, some of the observed differences may be due to differences in the type of units comprising the samples, which is also a limitation methodologically. In order to have a robust and representative sample of 8th Army in Korea, however, it was imperative to use both maneuver and support units in the sampling approach. This consideration also informed the inclusion of MHAT Horn of Africa and the USAREUR-based units, since these units also were comprised of both maneuver and support units.

2.3 Comparison Groups for Analyses

A key advantage of conducting MHAT missions is that multiple iterations contribute to extensive historical databases across many contexts. While this is the first assessment in Korea, having other MHAT databases serve as referents is important to set the findings in context. In previous MHATs, there has been a focus on comparisons across time; however, because of the unique location of MHAT-K8A, we focused on comparison groups that differed in location, rather than time. As such, no trend analyses were conducted here since it is the first assessment in Korea and it did not make sense to look at time as a factor across such vastly different settings.

We utilized data from three other MHAT studies, as well as data from a USAREUR-based brigade study that employed a similar survey methodology with comparable instruments. In all, two were conducted in Afghanistan (OEF 2012 and OEF 2013), one was conducted in the Horn of Africa (CJTF-HOA), and the other was conducted in Europe. Notably, these datasets provide excellent comparisons to both a population in an OCONUS permanent duty station, as well as a population in a non-combat/peacekeeping deployed environment. This is a significant strength, but it should be noted that these studies varied in sampling methodology (see section 2.1.2), and have two critical differences that must be considered when evaluating the comparative results: (1) Neither OEF samples surveyed

females, and (2) CJTF-HOA was predominantly (98%) composed of Reservists and National Guardsman.

Adjusted prevalence estimates were calculated using predicted probabilities from a logistic regression model or a linear regression model according to the categorical or continuous nature of the dependent variable. The basic statistical model included 'dataset' as a categorical predictor (but NOT as a measure of time) with MHAT-K8A serving as the referent against which other comparison datasets were contrasted. Values conveyed in graphs, tables, and in text are sample-adjusted for gender and rank where comparison data are presented. For presentation of these prevalence estimates, male junior enlisted Soldiers were used as the referent population because they comprised the majority of the sample. In the instances where scales or items were specific to the MHAT-K8A survey, we report raw values/percentages. All analyses were conducted using the Stata version 13.1 (Stata Corp., College Station, TX) and were replicated using the SPSS version 22 (IBM SPSS Statistics, IMB Corp, 2011).

Note that sample-adjusted values in this report are based on data combined across the multiple MHATs and from the USAREUR-based unit. As such, the values listed in this report may not exactly match values from previous MHAT reports. Values were adjusted based on the attributes of the combined database(s).

2.4 Focus Groups

The MHAT-K8A conducted fourteen cohort-specific focus groups with a total of 87 Soldiers (44 junior enlisted Soldiers (E1-E4) and 43 NCOs (E5-E7)) across major subordinate commands in 8th Army. MHAT-K8A also conducted four behavioral health provider focus groups with a total of 19 behavioral health providers across Korea.

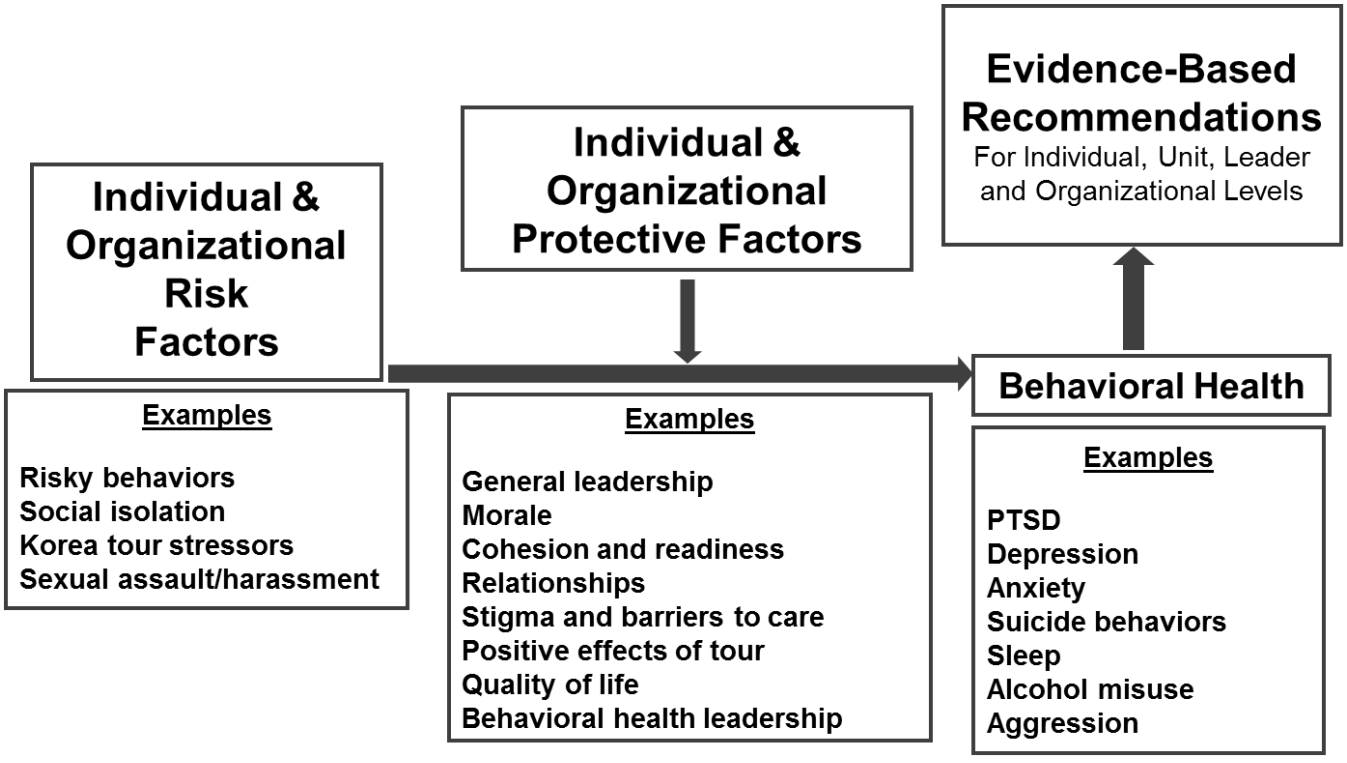
Themes from the Soldier and behavioral health provider focus groups augment survey-based data and are summarized in Chapters 9 and 10 of this report. Soldier focus group themes addressed perceptions of: 1) the mission, 2) quality of life, 3) unit climate, 4) coping, 5) social relationships, 6) behavioral healthcare, 7) alcohol, 8) suicide, and 9) transition challenges into Korea. behavioral health provider focus group themes addressed perceptions of: 1) general behavioral healthcare support needed in Korea, 2) suicide-related issues, 3) alcohol and substance abuse, 4) return-to-duty decisions and limitations, 5) resources, 6) treatment engagement adherence, and adaptation, 7) behavioral health collaborative care, 8) behavioral health provider well-being, 9) command relationships, and 10) telebehavioral health.

3 CONCEPTUAL OVERVIEW

The MHAT-K8A survey contains many common data elements contained in previous MHATs. MHAT surveys are adapted from the Land Combat Study developed by the Walter Reed Army Institute of Research (Hoge et al., 2004; Hoge et al., 2007; Riviere, 2008; Thomas et al., 2010). As in previous MHATs, the MHAT-K8A survey included items of emergent interest to operational and medical leadership in Korea. Below, data elements (i.e., survey domains) are organized under a modified version of the Soldier Adaptation Model (Bliese & Castro, 2003).

3.1 Soldier Adaption Model

Behavioral health indices can be viewed as outcome measures that are influenced by both risk factors and protective factors. The MHAT-K8A conceptual framework is based on the Soldier Adaptation Model (Bliese & Castro, 2003) and has been used to structure MHAT surveys and to frame the results in previous MHAT reports. MHAT-K8A survey included content nested in each of the following domains: 1) behavioral health indices (e.g., PTSD, depression, alcohol misuse), 2) individual and organizational risk factors (e.g., social isolation, tour stressors, risky behaviors), and 3) individual and organizational protective factors (e.g., cohesion, readiness, morale).



4 RESULTS: SAMPLE CHARACTERISTICS

4.1 Analytic Strategy and Presentation of Results

In general, the results section compares the current sample of US Soldiers in MHAT-K8A to other MHATs (OEF 2012, CJTF-HOA 2012, and OEF 2013) and a USAREUR-based brigade 2015. When data are not presented for certain datasets it is because comparison data on a particular scale/item did not exist. The standard tables and figures presented in the following sections provide between and/or within-sample comparisons based on gender- and rank-adjusted predicted probabilities for study samples. As described in previous sections, unless specifically noted, adjusted values represent predicted population prevalence estimates for male E1-E4 Soldiers. Junior enlisted male Soldiers were used as the referent population, as they represent the majority of Soldiers in both maneuver and support units. In both between- and within-sample comparisons, values that differ significantly ($p \leq .05$) from MHAT-K8A values are underlined.

Throughout the report, odds ratios are provided from logistic regression models. Odds ratios provide effect size estimates for the association between an exposure and an outcome. Mathematically, the odds ratio is the ratio of exposed individuals with a given outcome to unexposed individuals with a given outcome divided by the ratio of exposed individuals without a given outcome to unexposed individuals without the outcome, represented here as $\frac{a/c}{b/d}$, where:

		Outcome +	Outcome -
Exposure	+	a	b
	-	c	d

In short, an odds ratio greater than one indicates an increased probability of an outcome with a given exposure, an odds ratio of 1 indicates an equal probability of an outcome with a given exposure, and an odds ratio less than one indicates a decreased probability of an outcome with a given exposure.

In this report, we present odds ratios from logit models that are adjusted for gender and rank.

4.2 MHAT-K8A Sample Characteristics

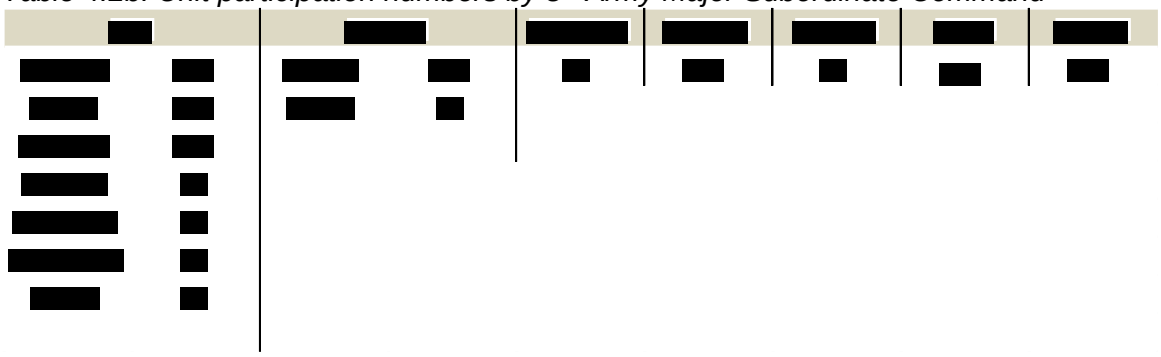
Table 4.2a provides a detailed description of the sample, with several notable characteristics important for understanding the study sample of Soldiers stationed in Korea. Importantly, 47.0% of Soldiers had dependents, and of those, 74% were on unaccompanied tours (stationed in Korea without their dependents). The majority of the sample resided in Areas I (46.3%) and III (28.4%), with only 7.8% residing in Area IV. This is consistent with the percentage of US Army forces distributed by Area across the Korean Peninsula. Unique to Korea is the presence of rotational units - units training and augmenting forces for [redacted] periods. In the MHAT-K8A sample, 23.9% of Soldiers were in rotational units, consistent with the 8th Army force distribution on the Korean Peninsula. There were no significant differences in behavioral health between rotational and non-rotational units, therefore we combined the data for these units for this report.

Table 4.2a. Sample Characteristics of MHAT Korea (N=1613)

Demographic Variable		n	Percent	Demographic Variable		n	Percent
Age				**ROK Location**			
	18-24	880	54.7		Area I	744	46.3
	25-29	338	21.0		Area II	281	17.5
	30-39	300	18.6		Area III	457	28.4
	39+	92	5.7		Area IV	126	7.8
Rank				**Primary Job**			
	E1-E4	1090	68.2		Combat Arms	498	34.3
	NCO	380	23.8		Medical	174	12.0
	Officer / WO	129	8.1		Non-Medical Support	778	53.7
Gender				**Unit Type**			
	Male	1339	83.3		Rotational	385	23.9
	Female	269	16.7		Non-Rotational	1228	76.1
Marital Status				**Deployment History**			
	Never married	780	50.6		Never Deployed	1011	67.5
	Married	634	41.1		At Least 1 Deployment	487	32.5
	Separated/Divorced/Widowed	128	8.3				
Dependents							
	No Dependents	849	52.9				
	Dependents not in Korea	561	34.9				
	Dependents in Korea	196	12.2				

Note: Percentages calculated without missing; may not total 100 due to rounding

Table 4.2b. Unit participation numbers by 8th Army Major Subordinate Command



4.3 Comparison Sample Characteristics

Table 4.3 provides details on the study samples across the five study populations: Korea, USAREUR, CJTF-HOA, OEF 2012 and 2013. Because most of our analyses use Korea as the referent group, significant differences ($p < .05$) in sample characteristics are discussed when different from the Korea sample in unadjusted logit and OLS regression models (although it should be noted that sample characteristics may differ among the comparison samples).

Compared to MHAT-K8A, USAREUR and CJTF-HOA were older, while OEF 2012 and 2013 study populations were younger. Uniquely, both OEF 2012 and OEF 2013 studies did not sample women;

however, compared to Korea, USAREUR and CJTF-HOA had smaller proportions of women. USAREUR and CJTF-HOA had higher ranking Soldiers and Officers; whereas OEF 2012 and 2013 samples did not differ from MHAT-K8A. CJTF-HOA was almost entirely Reserve/National Guard, whereas MHAT-K8A, USAREUR, and OEF 2013 were almost entirely Active Duty. OEF 2012 was the only study with large proportion of both Active Duty and Reserve/National Guard. Compared to MHAT-K8A, a greater proportion of USAREUR and CJTF-HOA Soldiers were married, but both OEF 2012 and 2013 samples did not differ significantly from MHAT-K8A. Due to the nature of the OEF 2012 and 2013 samples, the entirety of these samples had been on a deployment in a combat zone. Among the other study samples, both USAREUR and CJTF-HOA had more combat deployment experience.

Table 4.3. Sample Characteristics Across Comparison Studies

	Korea 2016 N=1613		USAREUR 2015 N=2317		CJTF-HOA 2012 N=505		OEF 2012 N=619		OEF 2013 N=849	
Demographic Variable	n	%	n	%	n	%	n	%	n	%
Age*										
18-24	880	54.7	1130	49.4	137	27.1	374	60.6	503	59.6
25-29	338	21.0	622	27.2	110	21.8	165	26.7	238	28.2
30-39	300	18.6	421	18.4	141	27.9	71	11.5	97	11.5
39+	92	5.7	116	5.1	117	23.2	7	1.1	6	0.7
Gender*										
Male	1339	83.3	2105	92.4	454	90.3	619	100.0	849	100.0
Female	269	16.7	174	7.6	49	9.7	N/A		N/A	
Rank*										
E1-E4	1090	68.2	1326	58.2	258	51.2	405	65.6	543	64.3
E5-E9	380	23.8	755	33.1	191	37.9	190	30.8	268	31.7
Officer / WO	129	8.1	199	8.7	55	10.9	22	3.6	34	4.0
Component [ı]										
Active	1605	99.9	2317	100.0	9	1.8	522	84.6	847	100.0
Reserve	2	0.1	N/A		46	9.1	1	0.2	N/A	
National Guard	N/A		N/A		450	89.1	94	15.2	N/A	
Marital Status*										
Married	634	41.1	1033	50.8	241	50.7	223	39.2	346	43.9
Unmarried	908	58.9	1000	49.2	234	49.3	346	60.8	443	56.1
Combat Deployment*										
Never	883	64.5	1199	52.8	216	43.2	N/A		N/A	
>=1	487	35.5	1072	47.2	284	56.8	619	100.0	849	100.0

Note: Percentages calculated without missing; may not total 100 due to rounding

* Significant differences in proportions between study populations ($p < .05$)

[ı] Statistical comparisons not made due to too few subjects per category

5 RESULTS: BEHAVIORAL HEALTH INDICES

This section reviews a variety of measures on behavioral health. We examine several indicators of psychological health disorders: post-traumatic stress disorder (PTSD), depression, anxiety, and suicidality. These disorders provide critical information on population-level well-being because they are prevalent in the general population and are also specifically important in military populations due to the unique exposures and stressful nature of military service. We also examine several behavioral health outcomes that are important for understanding behaviors that can negatively affect work performance and social functioning: alcohol misuse, sleep quality and quantity, and aggression.

5.1 Behavioral Health: Post-Traumatic Stress, Depression and Anxiety

Soldiers' ratings of depression, generalized anxiety, and post-traumatic stress (i.e., symptoms of post-traumatic stress disorder) were assessed using standardized, validated scales, including the PTSD Checklist (PCL: Weathers et al., 1993; Weathers et al., 2013), the Patient Health Questionnaire (PHQ: Kroenke & Spitzer, 2002; Spitzer et al., 1999) and the Generalized Anxiety Disorder scale (GAD-7: Spitzer et al., 2006). These survey instruments for PTSD, anxiety, and depression are considered standardized, validated scales that measure whether a Soldier reports symptoms consistent with DSM-IV-TR (American Psychiatric Association, 2000) for each behavioral health concern. In order to screen positive for depression or anxiety, Soldiers must have reported impairment in their work or inability to get along with other people at a "very difficult" level; and for post-traumatic stress, Soldiers had to have a total score of ≥ 50 on the PCL-S (or modified version of the PCL-5, see Appendix A). Details on scoring specific scales are available in previous MHAT reports and are consistent with other research with US Soldiers (Bliese et al., 2008; Hoge et al., 2004; Hoge et al., 2014; Thomas et al., 2010).

The prevalence estimates of Soldiers meeting criteria for post-traumatic stress, depression and anxiety are provided in Table 5.1. In general, Korea had fewer Soldiers meeting criteria for psychological health conditions compared to CJTF-HOA and OEF 2012 and was similar to the USAREUR and OEF 2013 samples. The estimated percentage of Soldiers meeting criteria for post-traumatic stress in Korea was significantly lower compared to CJTF-HOA and OEF 2012 of the estimated percentage of Soldiers meeting criteria for depression was significantly lower in Korea than CJTF-HOA, and the estimated percentage meeting criteria for anxiety was lower in Korea than CJTF-HOA, but higher than that observed in OEF 2013. Within Korea, gender and rank were not predictive of having post-traumatic stress, anxiety, or depression.

Table 5.1. Prevalence estimates across studies of Soldiers screening positive for post-traumatic stress, depression, and anxiety

Psychological Health Problems	Korea 2016	USAREUR 2015	CJTF-HOA 2012	OEF 2012	OEF 2013
Post-traumatic Stress	6.5%	6.3%	12.6%	13.5%	8.5%
Depression	3.5%	2.7%	6.4%	2.5%	2.2%
Anxiety	4.0%	3.8%	6.4%	3.3%	2.2%

Sample-adjusted values for rank and gender. Percent Meeting Screening Criteria

In the Korea sample, the percentage of Soldiers meeting criteria for any psychological problem (post-traumatic stress, depression, or anxiety) was 8.4%, which was similar to USAREUR and OEF 2013, but

significantly lower than that reported in CJTF-HOA and OEF 2012 (see Figure 5.1). Within Korea, gender and rank differences were not observed.

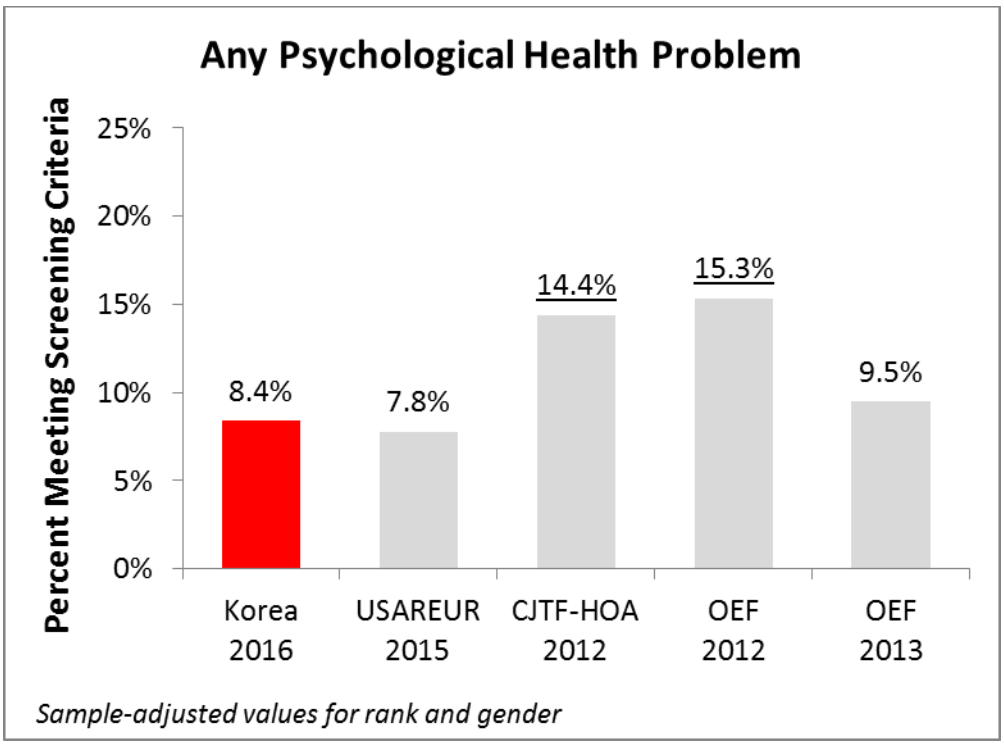


Figure 5.1. Prevalence of having any psychological problem by study

5.2 Suicide

5.2.1 Suicide Behavior

US Army suicide information was obtained from the Defense Suicide Prevention Office (DSPO) and was augmented by Department of Defense Suicide Event Report system reports. In 2015, US Army suicide completions in Korea were at their highest in four years, with 5 completed suicides (see Table 5.2.1). Although 5 suicides in this population of 18,378 Soldiers was not significantly higher than the US Army average as a whole, it was a marginally significant increase for the US Army in Korea (p = .10), indicating that close attention should be paid toward monitoring suicide in Korea over the coming years.

Table 5.2.1. Suicide completions by calendar year for US Army Soldiers in Korea from the Defense Suicide Prevention Office

	2012	2013	2014	2015
US Army Completed Suicides in ROK	3	3	1	5

Table 5.2.2 shows the characteristics of Soldiers that completed suicide in 2015.

Table 5.2.2. Characteristics of Soldiers that completed suicides in 2015 in Korea

5.2.2 Suicidality, Suicidal Ideation, and Self-Harm

In addition to obtaining data from DSPO (presented in previous section), we also included two measures of suicidality and self-harming behaviors on the survey. The first measure was included in order to compare across other studies, and the second measure was a more in-depth assessment of suicidality, but does not allow for comparisons between studies.

To compare across studies, we used one item from the PHQ-9 (Appendix A, Question 44). Table 5.2.2a presents the percentage of Soldiers endorsing past year suicidal ideation or thoughts of self-harm. In Korea 7.5% of Soldiers endorsed these thoughts, similar to the estimates for CJTF-HOA and OEF 2012 and 2013.

Table 5.2.2a. Prevalence estimates for Suicidal Ideation across Studies Using the PHQ-9

Suicide or Self-Harm Ideation (Past Month)	Korea 2016	CJTF-HOA 2012	OEF 2012	OEF 2013
Thoughts that you would be better off dead or hurting yourself in some way	7.5%	10.2%	8.1%	7.6%

Sample-adjusted values for rank and gender. Percent endorsing "Yes"

To provide an in-depth assessment of suicidality in Korea the Composite International Diagnostic Interview (CIDI) depression module (World Health Organization, 1997) was used. This measure captures several important components of suicidality: (1) rumination about death; (2) suicidal ideation without a plan; (3) suicidal ideation with a plan; and (4) lifetime history of suicide attempts (Appendix A, Question 52). Frequencies of Soldiers endorsing these items are presented in Table 5.2.2b. In this sample, 3.8% of Soldiers reported seriously thinking about committing suicide over the past year and 2.1% had made a plan to commit suicide.

Table 5.2.2b. Suicidality estimates for Soldiers stationed in Korea

Suicidality (Past Year)	Korea 2016
Often think about death, either your own or someone else's, or death in general?	16.0%
Seriously think about committing suicide?	3.8%
Make a plan for committing suicide?	2.1%
In your LIFETIME, have you ever attempted suicide?	6.3%

Raw percent endorsing "Yes"

5.2.3 Suicidal Ideation Risk Factors

To determine the extent to which several known risk factors were associated with suicidal ideation in Korea we used the endorsement of either (1) seriously thinking about suicide or (2) making a plan to commit suicide, and ran a series of logistic regression models with each individual risk factor (shown in

Figure 5.2.3), controlling for rank and gender. Social isolation had the strongest association with suicidal ideation. Soldiers in the lower 50th percentile of social isolation had 13.3 times the odds of reporting suicidal ideation, compared to those in the upper 50th percentile.

Sleep problems were also associated with suicidal ideation. Those reporting having trouble falling asleep, staying asleep, or sleeping too much for half of the days or more in the past month had 7.7 times the odds of experiencing suicidal ideation. When examining only married Soldiers, those reporting infidelity as being a problem in their relationship over the past year had nearly 7 times the odds of experiencing suicidal ideation.

Men and women did not differ significantly in suicidal ideation, but being an E-5 to E-9 was consistently predictive of lower risk of experiencing thoughts of suicide, compared to being an E1-E4.

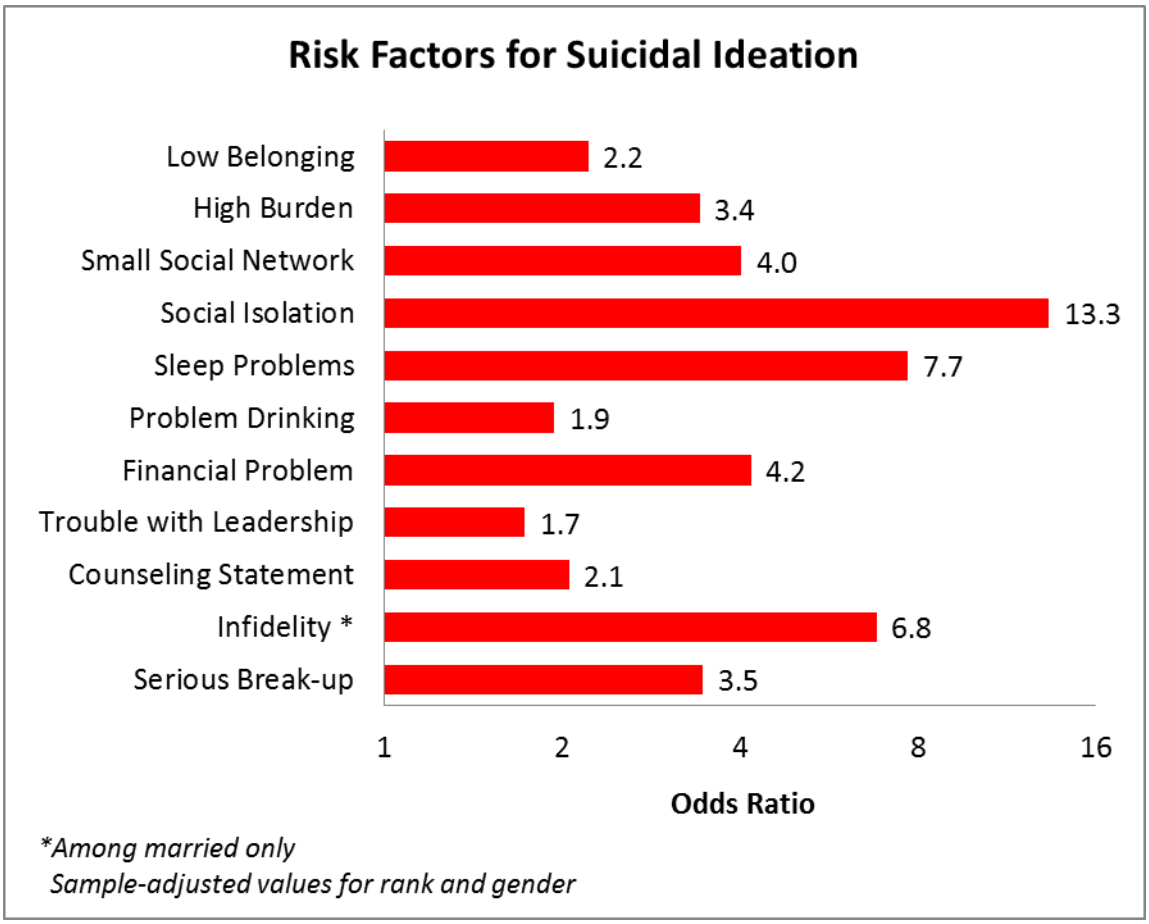


Figure 5.2.3. Associations between risk factors and thinking about or planning to commit suicide

5.3 Sleep

Only 26.6% of Soldiers reported getting 7 or more hours of sleep per 24 hours, with 73.4% reporting 6 or fewer hours of sleep (see figure 5.3a). On average, Soldiers in Korea reported getting 5.6 hours of sleep per 24 hours, which is the highest number of sleep hours reported across the five comparison studies, but still remains lower than the 7-8 hours of sleep recommended by the Centers for Disease Control and Prevention.

Korea was higher than USAREUR in those reporting sleep problems in the past month, and was not statistically different compared to CJTF-HOA, OEF 2012, and OEF 2013 (see Table 5.3). As shown in

Figure 5.3b, 21.5% of the Korea sample had moderate to severe insomnia measured using a modified version of the Insomnia Severity Index (Bastien et al., 2001; Appendix A, Questions 64-69).

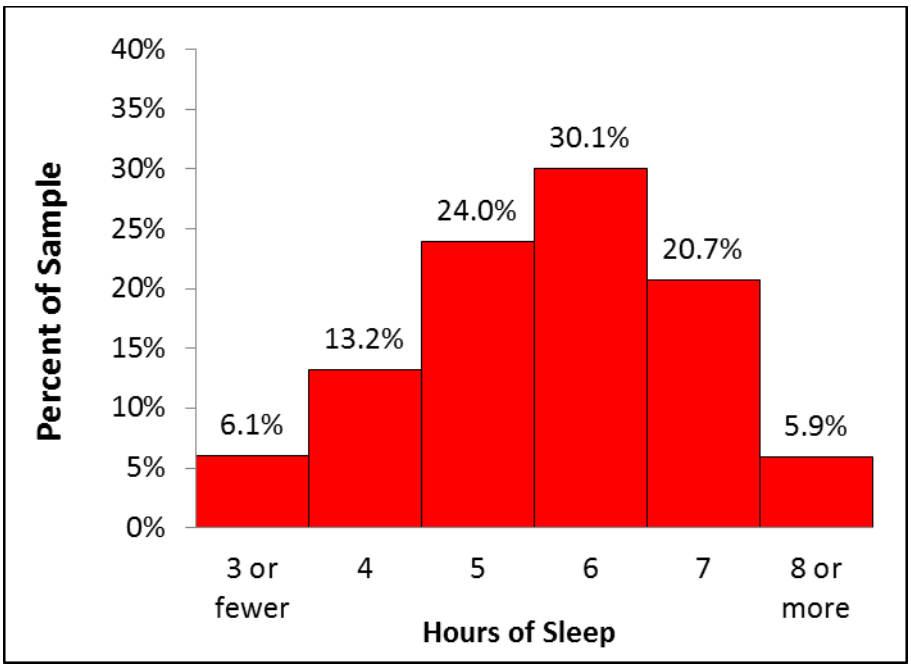


Figure 5.3a. Reported Hours of Sleep Per 24 hours

Table 5.3. Average Hours of Sleep Per 24 Hours and Sleep Problems by Study

	Korea 2016	USAREUR 2015	CJTF-HOA 2012	OEF 2012	OEF 2013
Average Hours	5.6	5.5	5.5	5.4	5.3
Sleep Problems	28.6%	20.4%	31.1%	26.3%	23.9%

Sample-adjusted values for rank and gender. Average hours reported and Percent endorsing any sleep trouble

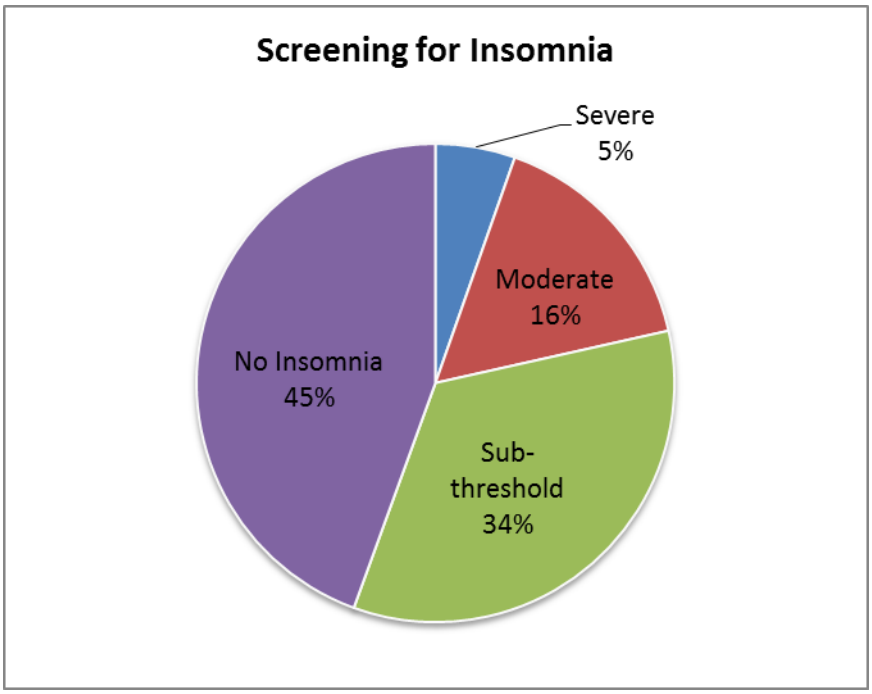


Figure 5.3b. Percentage of Sample Meeting Criteria for Insomnia

5.3.1 Relationship of Sleep to Behavioral Health

A significant linear relationship was observed between hours of sleep reported per day and the likelihood of meeting screening criteria for any psychological problem (see Figure 5.3.1), similar to findings from other studies.

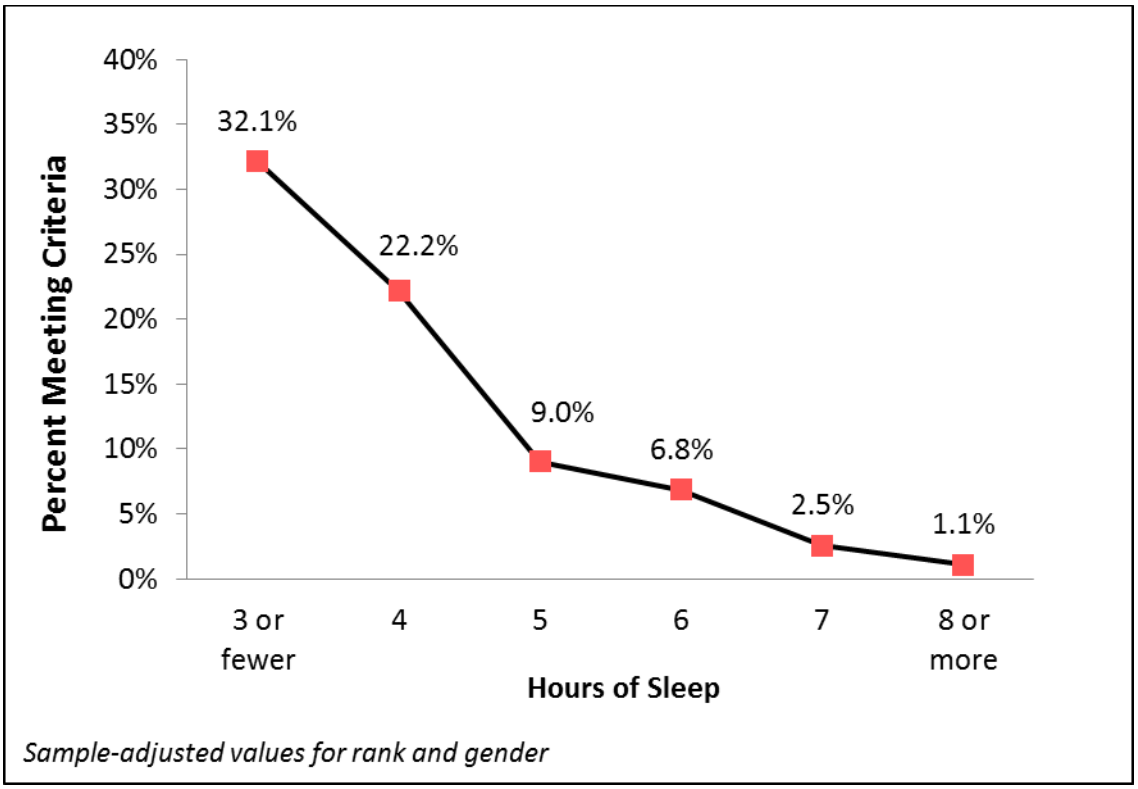


Figure 5.3.1. Relationship Between Sleep Hours and Any Psychological Condition

5.3.2 Relationship of Sleep to Accidents and Mistakes

Nearly 5% of Soldiers reported making a mistake or having an accident that affected the mission during their time in Korea (Appendix A, Question 72). Similar to findings from other studies, a significant linear relationship was observed between hours of sleep reported per day and the likelihood of making a mistake or having an accident (see Figure 5.3.2). These findings highlight the importance of leaders and Soldiers emphasizing healthy sleep patterns, as lack of sleep remains a concern in Korea and is especially concerning for mission related accidents.

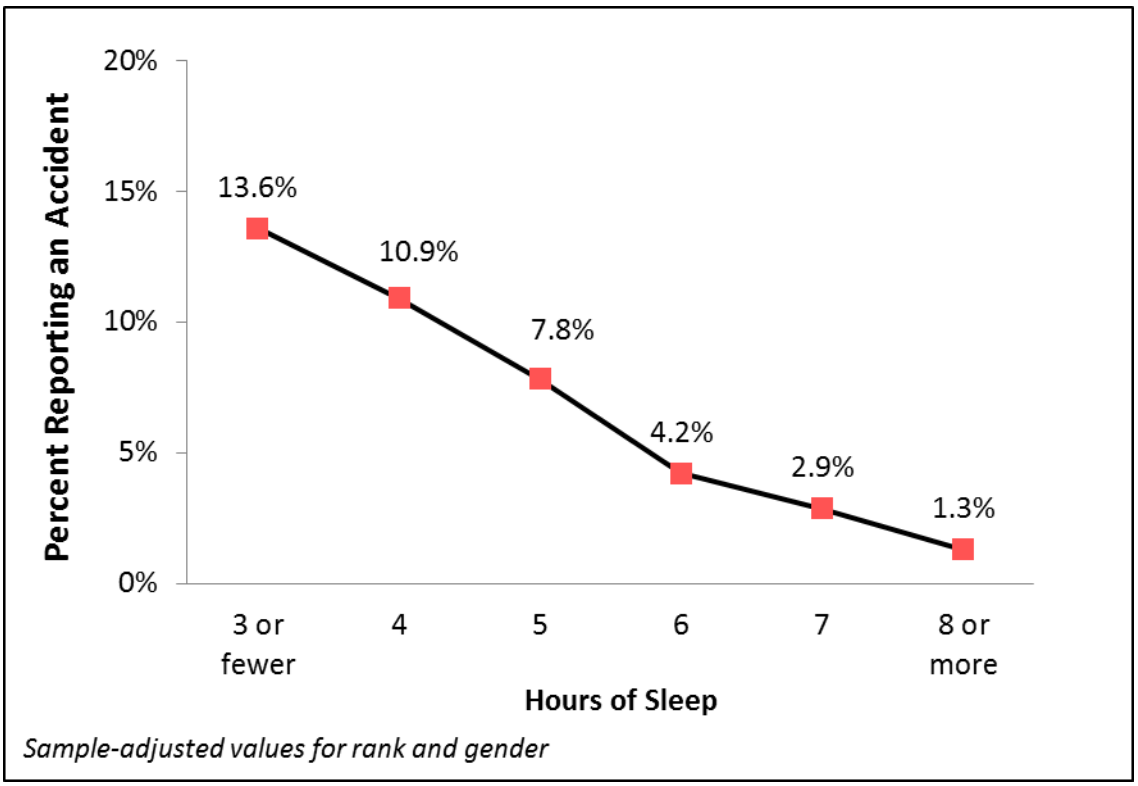


Figure 5.3.2. Relationship Between Sleep Hours and Mission-Related Accidents

5.4 Alcohol

One of the key behavioral health outcomes assessed in Korea was alcohol use. We examined alcohol misuse, risk factors for misuse, and alcohol related risk behaviors by Area in Korea and across studies. Although we compare to CJTF-HOA, it is worth noting that there was a two drink per day limit in that environment, limiting the interpretation of the data.

5.4.1 Alcohol Misuse

Alcohol misuse was classified using the Alcohol Use Disorders Identification Test-C (AUDIT-C; Bush et al., 1998), a measure of the frequency and quantity of alcohol consumption, as well as binge drinking (Appendix A, Questions 29-31). Korea had a significantly lower prevalence of alcohol misuse compared to USAREUR, but was significantly higher compared to CJTF-HOA - although again it is worth noting the two drink per day limit in CJTF-HOA (see table 5.4.1a).

Table 5.4.1a. Alcohol Misuse Across Studies

	Korea 2016	USAREUR 2015	CJTF-HOA* 2012
Alcohol Misuse	27.4%	37.7%	18.5%

Sample-adjusted values for rank and gender. Percent Meeting Screening Criteria

** two drink/day limit*

Within Korea, alcohol misuse was greatest in Area III, which differed significantly from Area I (see table 5.4.1b). Gender differences in alcohol misuse were not observed, but prevalence estimates for NCOs (28.2%) and Officers (33.3%) were higher than those of the junior enlisted (21.5%). Interestingly, 38.9% of Soldiers reported drinking more since being stationed in Korea, but this was predominantly driven by the junior enlisted, 60.4% of whom reported increased drinking. Both the lower percentage of alcohol misuse and the reported increase in drinking could be due to junior enlisted Soldiers reaching the legal drinking age while being stationed there.

Table 5.4.1b. Alcohol Use by Area within Korea

	Area I	Area II	Area III	Area IV
Alcohol Misuse	21.9%	27.1%	29.7%	23.9%

Sample-adjusted values for rank and gender. Percent Meeting Screening Criteria

5.4.2 Alcohol Misuse Risk Factors

To determine the extent to which several risk factors and psychological comorbidities were associated with alcohol misuse, a series of logistic regression models were run with each individual factor in Figure 5.4.2, controlling for rank and gender. Staying out past curfew had the strongest association with alcohol misuse, with those staying out past curfew since being in Korea having 4.4 times the odds of screening positive for alcohol misuse. Depression, anxiety, and post-traumatic stress were all significantly associated with alcohol misuse. Individuals screening positive for depression, anxiety, or PTSD had 1.5, 1.2, and 1.7 times the odds of screening positive for alcohol misuse, respectively.

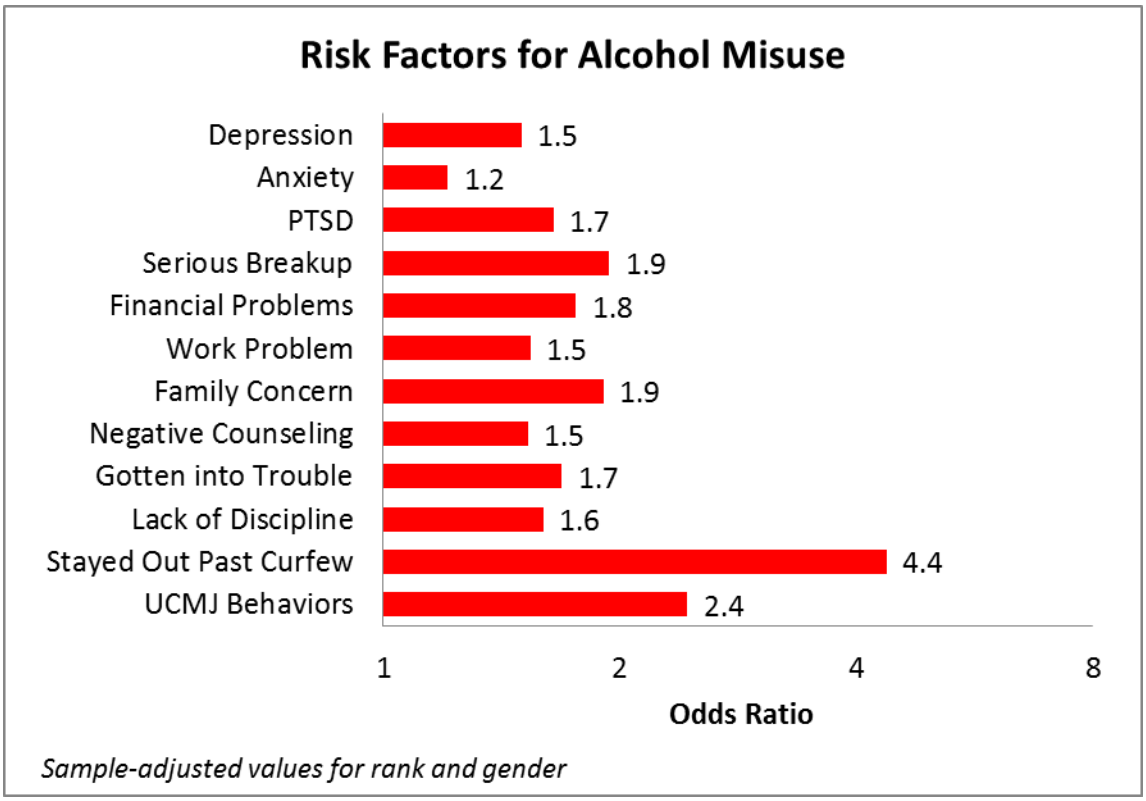


Figure 5.4.2. Associations between risk factors and screening positive for alcohol misuse

5.4.3 Alcohol Related Risk Behaviors

As shown in Table 5.4.3, the most commonly reported reason for using alcohol was to deal with boredom (21.3%), followed by use to calm down (18.2%) or forget about things (15.7%). In contrast, 1.6% of the sample reported that alcohol affected their work.

Table 5.4.3 Percentage of sample reporting alcohol-related risk behaviors and reasons for use

Alcohol Related Risk Behaviors	Korea 2016
Used alcohol to deal with boredom	21.3%
Used alcohol to calm down	18.2%
Used alcohol to forget about things	15.7%
Used alcohol to sleep	13.6%
Drinking affected your work	1.6%

Raw percent endorsing "Yes"

5.5 Aggression

Soldiers' ratings of aggressive behaviors were measured using four items asking about shouting, property destruction, physical threats, and assault (Appendix A, Question 49). Within the Korea sample, 49.8% endorsed engaging in at least one of these behaviors one or more times over the past month. A greater proportion of women (58.3%) reported these behaviors, compared to men (48.2%), with women

having 1.6 times the odds of endorsing one or more of these behaviors compared to men, after adjusting for rank. Figure 5.5 presents the frequency of total and individual aggressive behaviors by gender. Women reported 'yelling or shouting' significantly more than men, but did not differ significantly on any of the other behaviors. It is worth noting that these same items were assessed on the USAREUR survey and similar gender differences across items were observed.

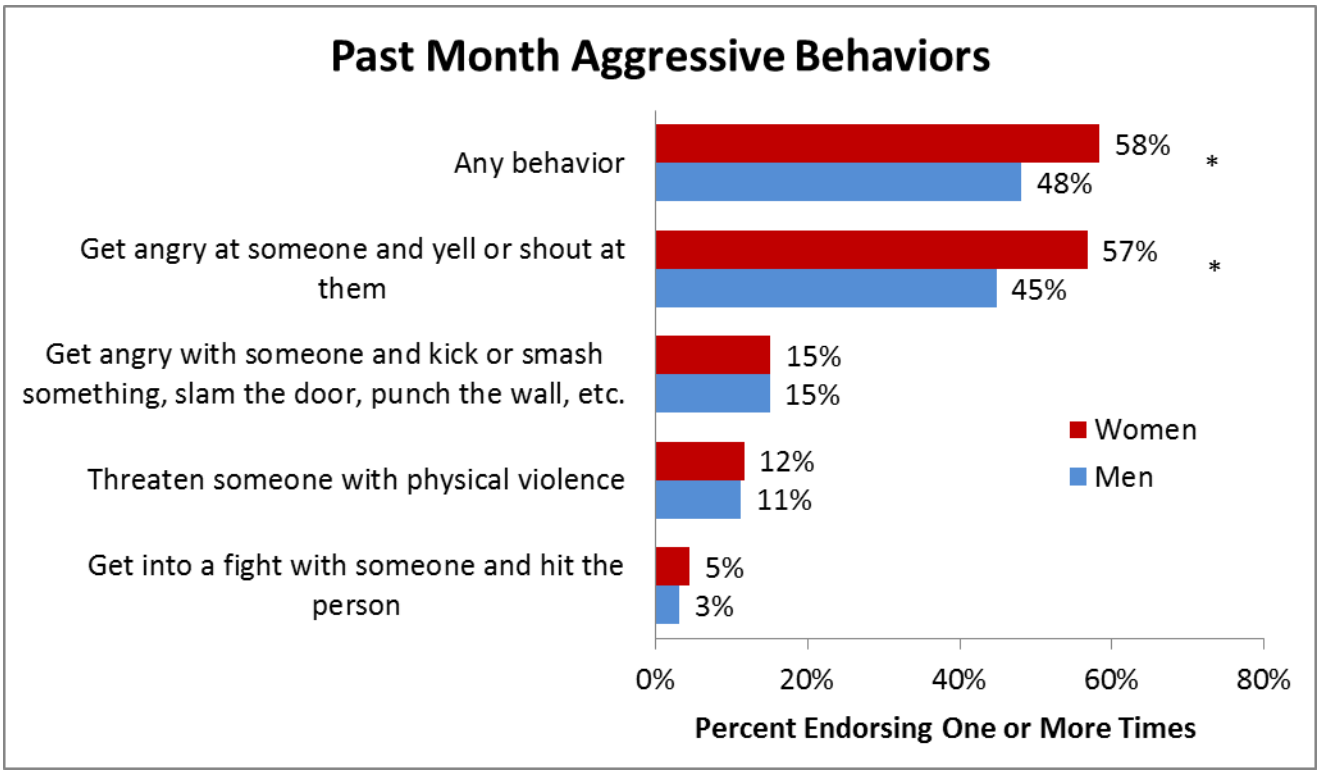


Figure 5.5. Past month aggressive behaviors by gender
**significant difference ($p < .05$)*

6 RESULTS: RISK FACTORS

Changes in behavioral health indices are often associated with changes in risk factors. Stressors are often individual predictors of behavioral health problems, or are factors that can exacerbate an already existing problem. Stressors such as sexual harassment, sexual assault, and work-related stress are factors that can directly impact well-being. Other risk factors may decrease one's ability to cope with acute and chronic stressors. For example, social relationships and social belonging are critical for individuals to cope with stressors and feel a sense of purpose. In addition, having access to external resources to assist with coping (e.g., behavioral health providers, chaplains) is critical for psychological well-being during periods of high stress. Lastly, other risky behaviors (e.g., having unprotected sex, drug use, financial problems) are also related to poor downstream outcomes.

6.1 Risky Behaviors

We examined several risky behaviors and indicators that an individual might be experiencing stress or have an increased risk for self-harming thoughts or behaviors since being stationed in Korea (Appendix A, Question 33). These items are presented in Figure 6.2a. Receiving a negative counseling statement was the most highly endorsed item (17.1%), followed by having friends or family express concern (14.3%), or experiencing a break-up (13%). These were followed by behaviors generally associated with career risk: demonstrating lack of discipline, getting in trouble, violating curfew, or engaging in behaviors that risk punishment under UCMJ. In general, there was a very low reporting of prescription drug misuse (1.2%) or the use of illicit drugs (0.5%).

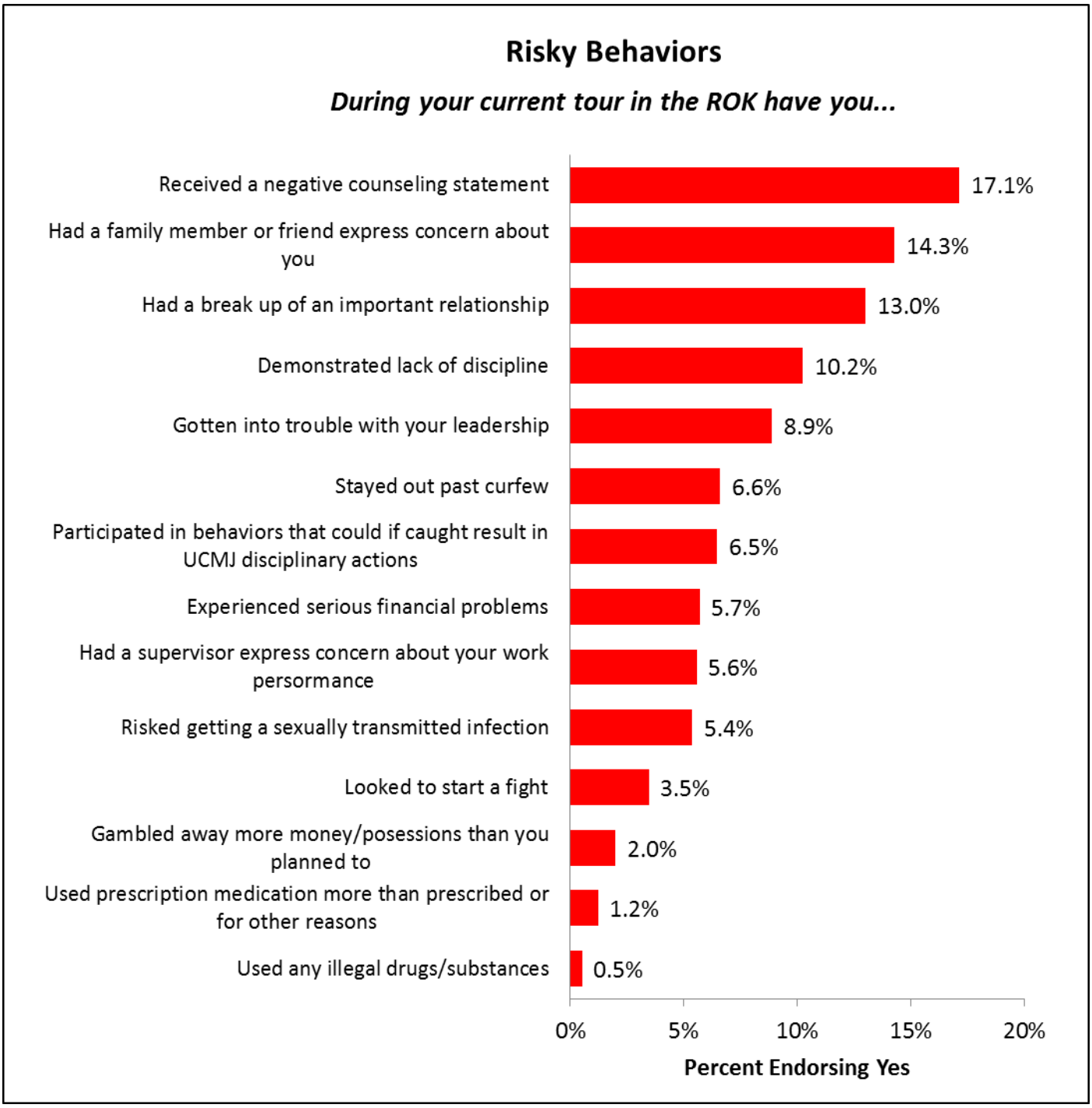


Figure 6.2a. Raw percentages of Soldiers endorsing risky behaviors

Of the above, several have employment-related implications. We examined how these employment-related risky behaviors were associated with screening positive for alcohol misuse or any psychological health condition. We examined four risky behaviors: demonstrating lack of discipline, receiving a counseling statement, violating curfew, and engaging in behaviors that risk punishment under UCMJ. All of these were significantly associated with an increased risk of screening positive. Those reporting engaging in behaviors that violate UCMJ were 4.7 times as likely to screen positive for a psychological health problem, and those that reported demonstrating a lack of discipline had 4.1 times the risk of screening positive for a psychological health problem. Those reporting breaking curfew were 4.4 times as likely to screen positive for alcohol misuse.

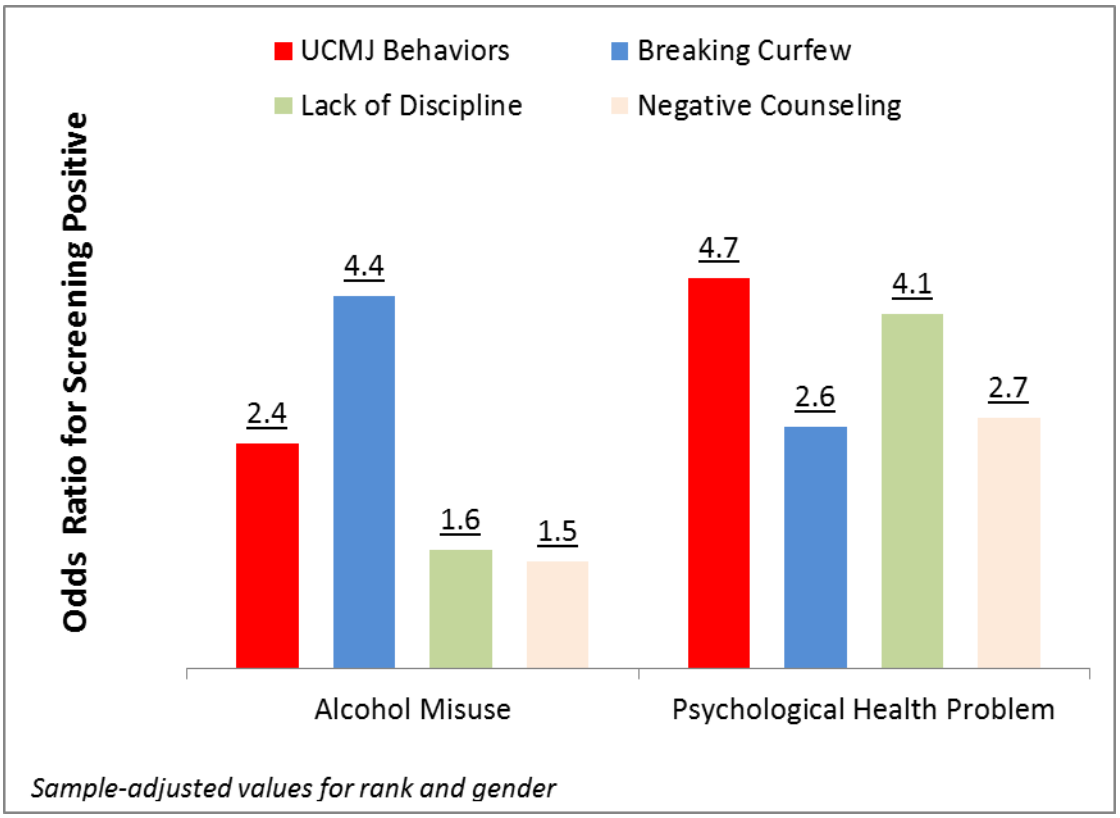


Figure 6.2b. Odds ratios for screening positive for alcohol misuse or having any psychological health problem based on career-related risky behaviors

6.2 Social Isolation

Social isolation, social exclusion, and belonging have been shown to be strong predictors of mental health outcomes such as depression and suicidality, as well as global predictors of well-being such as general health and life satisfaction. Because of the transient nature of US forces in Korea, the distance from the US and the percentage of individuals on unaccompanied tours, social relationships may be more difficult to develop for Soldiers stationed in Korea. We examined individual social engagement using the Interpersonal Support Evaluation List (ISEL) belonging subscale (Cohen & Hoberman, 1983; Appendix A, question 46). Of the Soldiers stationed in Korea, nearly 30% felt it would be hard to find someone to go to a movie with or to go on a day trip with, 27.3% felt they didn't get invited to do things with others often, and 19% felt they could not find someone to go to lunch with if they wanted to (Table 6.3a). Using a measure assessing loneliness (Hughes et al., 2004; Appendix A, Question 47), about one-third of the study sample felt 'left out' or 'isolated from others', while nearly 40% reported 'lack of companionship' either 'sometimes' or 'all of the time' (Table 6.3b).

The prevalence estimates of loneliness in Korea, while high, were similar to USAREUR Soldiers stationed in Germany, with the exception of higher reports of feeling 'lack of companionship' among those stationed in Korea (38.1% versus 35.0%; Table 6.3b). Examining differences within Korea, we used the sum of the loneliness items. Findings suggest that Area IV had higher loneliness ratings, and that officers had lower loneliness ratings compared to junior enlisted (Table 6.3c), with no gender differences observed.

Table 6.3a. Difficulty with social engagement

Social Engagement	Korea 2016
Hard to find someone to go on a day trip	27.8%
Hard to find someone to go to a movie	28.8%
Don't get invited to do things with others often	27.3%
Can't find someone to have lunch with	19.0%

Raw percent endorsing "Probably True" or "Definitely True"

Table 6.3b. Feelings of social isolation and loneliness in Korea and USAREUR

Social Isolation	Korea 2016	USAREUR 2015
Lack companionship	38.1%	35.0%
Feel left out	29.7%	29.1%
Feel isolated from others	31.0%	28.9%

Sample-adjusted values for rank and gender. Percent endorsing "Sometimes" or "Often"

Table 6.3c. Social isolation and loneliness by Area and rank in Korea

	Area I	Area II	Area III	Area IV
Social Isolation (3-item average)	4.2	4.2	4.4	4.6

Sample-adjusted values for rank and gender

	E1-E4	E5-E9	Officer
Social Isolation (3-item average)	4.3	4.3	3.9

Sample-adjusted values for gender

Figure 6.3 shows the association of loneliness with mental health outcomes. Findings suggest that individuals high in social isolation have 14.5 times the odds of screening positive for anxiety, 11.9 times the odds of screening positive for depression, and 7.8 times the odds of screening positive for PTSD. Although significant, loneliness was only associated with 1.6 times the odds of screening positive for alcohol misuse. Examining physical health, loneliness was associated with 3 times the odds of rating ones overall health as fair, poor, or very poor (results not shown).

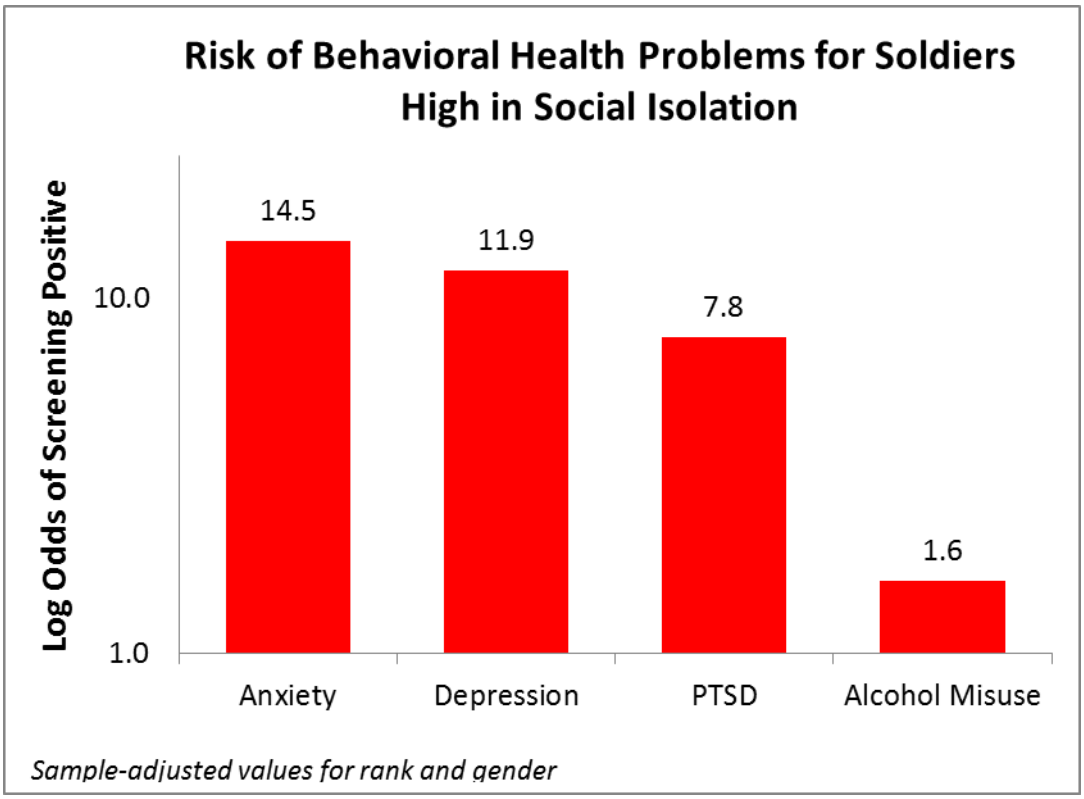


Figure 6.3. Risk of behavioral health problems for those high in social isolation

6.3 Tour Stressors

Many chronic tour-specific stressors occur that can decrease well-being and adversely impact behavioral health. We assessed several tour-specific stressors related to living and work conditions (Appendix A, Question 48). Not getting enough sleep and lack of privacy or personal space were the most frequently reported, with nearly 20% of Soldiers reporting these as being a high or very high concern (see Figure 6.3). This was consistent with focus group comments, where nearly all Soldiers brought up barracks conditions as a major source of concern due to lack of privacy from policies requiring doors to remain open, and poor sleep conditions due to being woken up for nighttime inspections. Threat from North Korea was not rated as a top concern, with only 6.8% of Soldiers reporting this as a high or very high concern. Specific to the Korea mission, more than 15% of Soldiers reported high or very high concern about not having the right equipment or repair parts. Reports of equipment shortages were lower in Area II and Area III, compared to Area I (data not shown). For every tour stressor, those who endorsed the stressor as being a high or very high concern were significantly more likely to meet screening criteria for a psychological health problem.

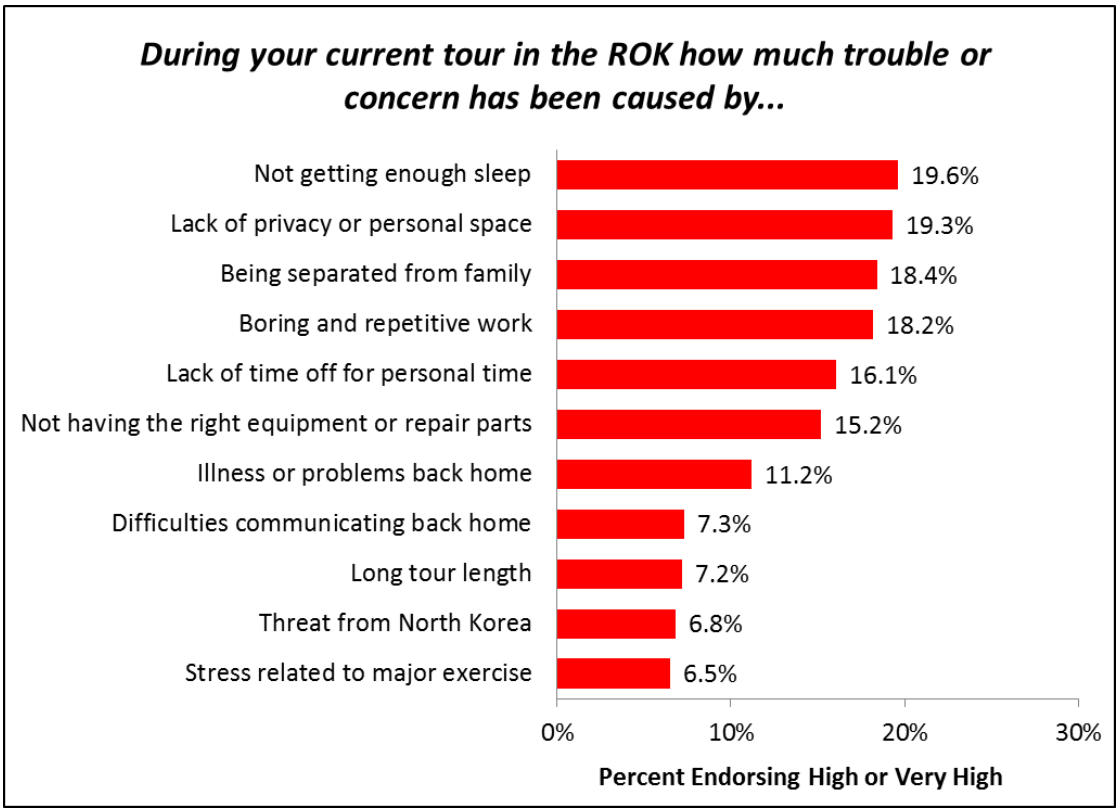


Figure 6.3. Tour stressors in Korea

6.4 Sexual Harassment/Assault

Sexual assault and sexual harassment were assessed using individual 1-item questions asking specifically if a person had been sexually assaulted or sexually harassed (Appendix A, Questions 34 and 35). These questions have lower specificity compared to multi-item 'gold standard' instruments, and may underestimate true population rates, but are widely accepted for survey research and have been used previously in other epidemiological studies of military and Veteran personnel (i.e., the Millennium Cohort Study). Because we were interested in sexual harassment and sexual assault in Korea, the timeframe for response was while the Soldier was in Korea (an average of 7.7 months in this sample).

For sexual assault, 1% of the total sample reported being sexual assaulted during their time in Korea (this roughly equates to 1.57% for a 12-month period), with 0.5% of men reporting and 3.6% of women reporting sexual assault (this very roughly equates to 0.78% and 5.61% for a 12-month period for men and women, respectively). These estimates are similar to those reported for the Army in the RAND report on sexual assault and sexual harassment in the US military (RAND, 2014) where Army-wide 12-month prevalence was reported at 1.46% combined, with 0.95% of men reporting and 4.69% of women reporting sexual assault. We also found that 0.8% of men and 2.0% of women were unsure of whether they were sexually assaulted.

For sexual harassment, 3.4% of the total sample reported experiencing being sexually harassed since being in Korea; 1.3% of men and 13.8% of women, with 1.0% reporting 'unsure'. Comparison data for these estimates are not provided, as the 1-year estimates from the RAND report are based on a more sensitive measure that combines sexually hostile work environment and quid-pro-quo, and the Millennium Cohort Study assesses three-year incidence rates.

Table 6.4. Sexual assault and sexual harassment

	Male	Female	All
	1226 n(%)	253 n(%)	1479 n(%)
Assault			
Yes	6 (0.5)	9 (3.6)	15 (1.0)
Unsure	10 (0.8)	5 (2.0)	15 (1.0)
Harassment			
Yes	16 (1.3)	35 (13.8)	51 (3.4)
Unsure	9 (0.7)	6 (2.4)	15 (1.0)
Observed			
Yes	44 (3.6)	28 (11.1)	72 (4.9)

Numbers reported based on time in Korea which varied across individuals

Nearly 5% of Soldiers reported observing sexual harassment during their time in Korea, 3.6% of men and 11.1% of women. Figure 6.4 show the various actions men and women took during or after observing sexual harassment. Women most frequently reported they 'Told an authority about the situation' (32%) or 'Confronted the perpetrator' (25%) and least frequently reported they 'Stepped in to separate' (4%), but never reported 'Did not take action' (0%). Men most frequently 'Asked person if they needed help' (27%), but never reported 'Sought help to reduce tension' (0%). Nearly 14% of men that observed sexual harassment reported they 'Did not take action'.

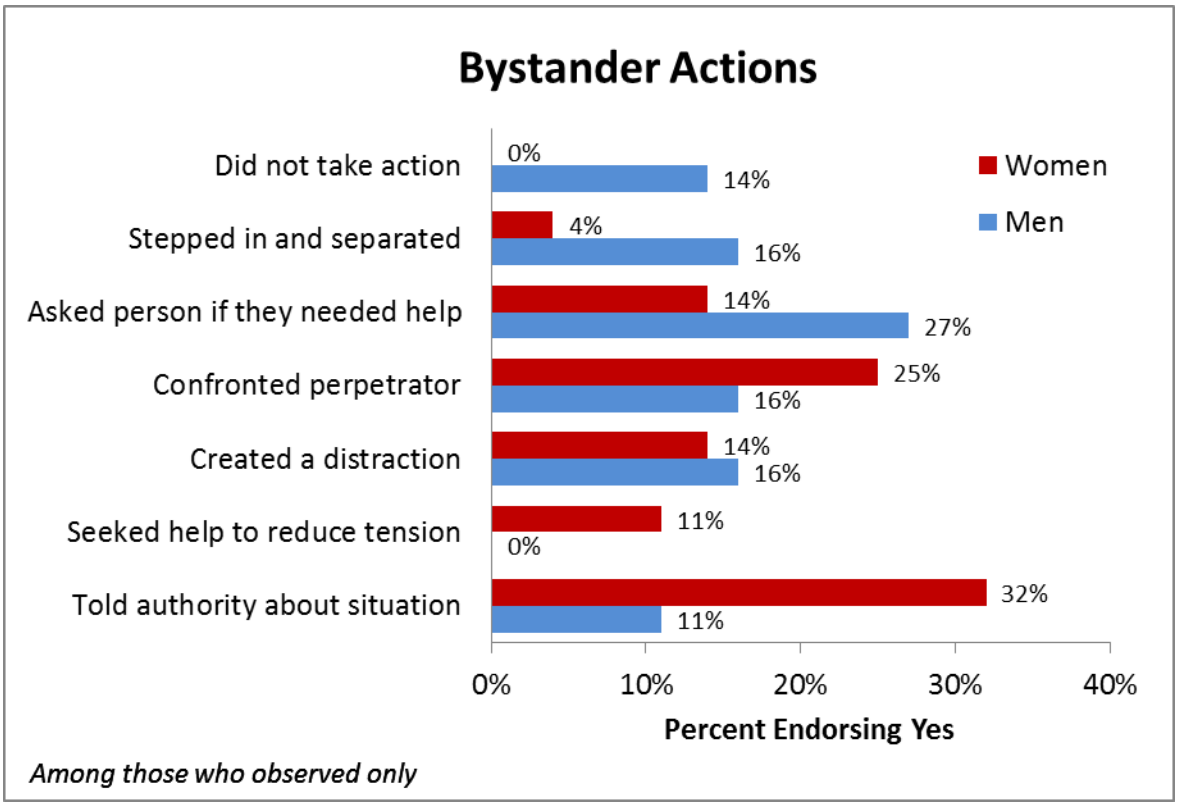


Figure 6.4. Actions taken by men and women reporting to have observed sexual harassment while in Korea

7 RESULTS: PROTECTIVE FACTORS

Protective factors are the third category of variables in the Soldier Adaptation Model. Protective factors contribute to resilience or the ability to persist in the face of challenges and to bounce back in the face of adversity (Reivich et al., 2011). Many of these factors can directly buffer the effects of stressful environments (Cohen & Wills, 1985). Factors thought to be associated with reducing the negative effects of stress and increasing individual resilience include positive unit climate (such as leadership, morale, readiness and unit cohesion), strong interpersonal relationships, factors related to quality of life (e.g., housing, recreation), and access to behavioral healthcare.

7.1 Unit Climate: Leadership, Morale, Readiness and Cohesion

Factors such as small unit leadership, unit cohesion, and perceived readiness are directly related to well-being and often play a role in attenuating the link between deployment stressors and behavioral health outcomes (Adler & Castro, 2013; Bliese, 2006; Bliese & Castro, 2003). Just as loneliness and social isolation are potential risk factors for behavioral health problems, characteristics of the unit climate that promote connection can contribute to health in the context of work-related stress (DeWall & Baumeister, 2006).

7.1.1 Leadership

Figure 7.1.1 provides ratings for small unit leadership using short versions of the WRAIR Leadership scales (Appendix A, Question 57). Over 70% of the study sample rated their Platoon Sergeant (or equivalent) and Platoon Leader (or equivalent) as being high in leadership quality, similar to that found in USAREUR. Officers and NCOs were more likely to rate their Platoon Sergeant and Platoon Leader as high in leadership quality, compared to junior enlisted.

Table 7.1.1. Percent of Soldiers rating their Platoon Sergeant and Platoon Leaders as 'high' in leadership ability between studies

	Korea 2016	USAREUR 2015
NCO Leadership	71.4%	69.9%
Officer Leadership	72.6%	69.7%

Sample-adjusted values for rank and gender. Percent endorsing Positive Ratings

7.1.2 Individual and Unit Morale

Individual and unit morale were measured with single items asking the Soldier to rate individual morale as well as that of his/her unit (Appendix A, Question 54). Individual and unit morale were significantly higher in Korea compared to all other samples, with the exception of individual morale being similar to USAREUR. Nearly twice as many Soldiers reported being 'high' or 'very high' in individual and unit morale compared to the CJTF-HOA, OEF 2012, and OEF 2013 samples.

Table 7.1.2. Percent of Soldiers rating morale as high or very high across samples

	Korea 2016	USAREUR 2015	CJTF-HOA 2012	OEF 2012	OEF 2013
Individual Morale	47.5%	47.1%	27.7%	19.2%	24.0%
Unit Morale	28.0%	23.0%	13.8%	11.2%	15.2%

Sample-adjusted values for rank and gender. Percent endorsing "High" or "Very High"

7.1.3 Unit Cohesion and Readiness

We also examined unit readiness and unit cohesion using three- and four-item scales (Appendix A, Question 60) that were averaged and dichotomized into 'high' and 'low'. Both readiness and cohesion scores were significantly lower than scores reported in OEF 2012 and OEF 2013 (See Table 7.1b). Overall, 56.7% of the sample in Korea rated their readiness as high and 61.5% rated their unit cohesion as high. Note that these comparison data were collected from platoons in combat. It is logical to presume that the combat setting elicits higher ratings of cohesion and readiness as they are consequently linked to combat effectiveness and preparedness.

Readiness was rated similarly among NCOs and junior enlisted, while officers were twice as likely to rate readiness as high. Cohesion was rated higher among NCOs and officers, with NCOs having a 40% greater likelihood or reporting high cohesion, and officers were 3.6 times as likely to rate unit cohesion as high.

Figure 7.1.3. Percent of Soldiers rating their unit readiness and unit cohesion as 'high' between studies

	Korea 2016	OEF 2012	OEF 2013
Unit Readiness	56.7%	81.4%	76.3%
Unit Cohesion	61.5%	77.8%	70.4%

Sample-adjusted values for rank and gender. Percent rating 'high'

7.2 Marriage and Committed Relationships

We asked several questions about marriage and significant relationships, including questions on marital quality (Appendix A, Question 87), infidelity (Appendix A, Question 85), and risk of divorce (Appendix A, Question 83). The questions about infidelity and risk for divorce could arguably be considered risk factors; for organizational purposes in reporting on relationships we summarize findings about infidelity and divorce here. In terms of military family status, 53.6% were not married, 30.1% were married but did not have dependents in Korea (unaccompanied), and 9.1% were married with dependents in Korea (7.2% of the sample was missing data). Across the Korea sample, the average rating of marital quality was 4.02 on a 5-point scale, indicating general satisfaction with marriage was high. We also examined whether individuals were happier in their marriage if they had their spouses in Korea with them, or it they were unaccompanied. In an unadjusted model, average marital quality ratings were significantly higher among married Soldiers with dependents in Korea (M = 4.30, SD = .87), compared to married Soldiers

without dependents (M = 4.09, SD = .05; *p* = .04). We also examined three common behavioral health issues between married and unaccompanied and married and accompanied Soldiers (Table 7.2a). Between the groups, the married without dependent and married with dependents did not differ from those not married in screening positive for anxiety or depression, but those married with dependents were significantly less likely to screen positive for alcohol misuse.

Table 7.2a. Prevalence estimates across studies of Soldiers screening positive for depression, anxiety, or alcohol misuse by marital status and accompanied status

	Not Married	Unaccompanied	Accompanied
Depression	3.7%	4.9%	2.8%
Anxiety	4.2%	6.0%	2.0%
Alcohol Misuse	25.4%	23.3%	17.7%

Sample-adjusted values for rank and gender. Percent screening positive

Comparing across samples, marital quality in Korea was similar to CJTF-HOA and OEF 2012, but was higher than USAREUR, and lower than OEF 2013 (Table 7.2b). No differences between studies were observed with regard to the percentage experiencing infidelity or risk of divorce.

Table 7.2b. Marital quality, infidelity, and planning to divorce

	Korea 2016	USAREUR 2015	CJTF-HOA 2012	OEF 2012	OEF 2013
Marital Quality	4.10	3.97	4.14	4.18	4.27
Infidelity	11.7%	12.4%	11.0%	11.5%	6.5%
Planning Divorce	12.5%	9.5%	8.7%	10.9%	12.8%

Sample-adjusted values for rank and gender. Quality on scale of 1-5 and Percent endorsing "Yes"
**Among married only*

7.3 Stigma and Barriers to Care

Access to behavioral healthcare is critical to assist Soldiers with coping during acute crises as well as treating mental health conditions. Stigma associated with seeking behavioral healthcare is particularly problematic in the military when healthcare and health conditions are directly related to employment. In addition, as has been the case in other MHAT surveys and surveys conducted at home station, 2-3 times as many Soldiers screening positive for a psychological health problem reported concerns about barriers to care and stigma compared to those who did not screen positive.

We assessed stigma and barriers to care with measures used in CJTF-HOA, OEF 2012 and OEF 2013 surveys. Table 7.3a provides prevalence estimates for Soldiers reporting ‘Agree’ or ‘Strongly Agree’ to each item. Across every item for stigma, the Korea sample had approximately half as many Soldiers endorsing any of the stigma items compared to the OEF samples. These lower rates of endorsement of

stigma-related items may be a function of the fact that over time attitudes have changed and overall rates of stigma have fallen (e.g., Quartana et al., 2014), or that the 8th Army handles these issues differently, or a combination of these two factors.

Table 7.3a. Stigma associated with behavioral health across samples

Stigma Item	Korea 2016	CJTF-HOA 2012	OEF 2012	OEF 2013
It would be too embarrassing	9.6%	19.3%	18.5%	18.0%
It would harm my career	12.5%	17.3%	19.6%	19.3%
Members of my unit might have less confidence in me	13.2%	23.8%	24.7%	25.6%
My unit leadership might treat me differently	11.6%	23.3%	24.8%	23.3%
My leaders would blame me for the problem	6.3%	16.2%	15.6%	17.2%
I would be seen as weak	11.1%	22.3%	26.0%	25.4%

Sample-adjusted values for rank and gender. Percent endorsing "Agree" or "Strongly Agree"

With regard to stigma within the Korea sample, Soldiers screening positive for a psychological health problem reported greater concerns about stigma across all items, compared to those without a psychological condition (Table 7.3b). In addition, there were no observed differences by gender, but there were significant differences by rank. Officers were nearly twice as likely to endorse 'agree' or 'strongly agree' across all items associated with stigma, with the exception of the item 'it would be too embarrassing', compared to junior enlisted. Senior and junior enlisted were similar in terms of their concerns about stigma. There were minimal differences in item frequencies between men and women, and there was no pattern indicating substantial differences in stigma or barriers between areas.

Table 7.3b. Stigma associated with behavioral health by psychological health

Stigma Item	Do Not Screen Positive	Screen Positive
It would be too embarrassing	7.5%	18.6%
It would harm my career	10.2%	28.6%
Members of my unit might have less confidence in me	10.9%	35.0%
My unit leadership might treat me differently	9.1%	30.9%
My leaders would blame me for the problem	4.3%	26.0%
I would be seen as weak	8.9%	31.6%

Sample-adjusted values for rank and gender. Percent endorsing "Agree" or "Strongly Agree"

Table 7.3c provides similar information on barriers to seeking behavioral health care/treatment. The most frequently reported barriers to care were difficulty getting time off work (11.0%) and difficulty getting an appointment (7%). Although these percentages are relatively low, they are consistent with a theme in Soldier focus groups where concerns were expressed about the difficulty of obtaining an initial appointment and follow-up appointments. We also examined differences between studies, and similar to what was observed for stigma, there were fewer barriers to receiving care in Korea, compared to CJTF-HOA, OEF 2012 and OEF 2013.

Table 7.3c. Barriers to seeking behavioral healthcare across samples

Barrier Item	Korea 2016	CJTF-HOA 2012	OEF 2012	OEF 2013
Mental health services aren't available	2.7%	7.3%	5.4%	4.3%
I don't know where to get help	4.7%	11.3%	9.3%	7.1%
It is difficult to get an appointment	7.2%	7.5%	8.7%	8.4%
There would be difficulty getting time off work for treatment	11.0%	11.6%	18.7%	17.6%
It's too difficult to get to the location where the mental health specialist is	4.4%	6.9%	9.1%	9.6%
My leaders discourage the use of mental health services	4.5%	5.2%	6.2%	5.3%

Sample-adjusted values for rank and gender. Percent endorsing "Agree" or "Strongly Agree"

With regard to barriers to care within the Korea sample, Soldiers screening positive for a psychological health problem reported greater concerns about barriers across all items, compared to those without a psychological problem (Table 7.3d). In addition, there were no observed differences by gender, but there were significant differences by rank. NCOs had a greater likelihood of endorsing all items except 'mental health services aren't available' and 'my leaders discourage the use of mental health services'. Junior enlisted were more likely to report that their 'leaders discourage the use of mental health services'.

Table 7.3d. Barriers to seeking behavioral healthcare by psychological health

Barrier Item	Do Not Screen Positive	Screen Positive
Mental health services aren't available	2.1%	10.8%
I don't know where to get help	4.0%	11.9%
It is difficult to get an appointment	5.4%	16.6%
There would be difficulty getting time off work for treatment	8.4%	24.6%
It's too difficult to get to the location where the mental health specialist is	3.2%	8.2%
My leaders discourage the use of mental health services	3.8%	10.4%

Sample-adjusted values for rank and gender. Percent endorsing "Agree" or "Strongly Agree"

7.4 Positive Effects of Tour

To examine the positive effects of being stationed in Korea, we asked nine questions about specific things Soldiers might benefit from or enjoy during their tour and asked them to rate each statement on a five point scale ranging from 'strongly disagree' to 'strongly agree' (Appendix A, Question 63). Two of the top four positive aspects of the tour were interactions with KATUSA (Korean Augmentation to the United States Army) and Korean military, indicating that Soldiers enjoy working with foreign military members in Korea – something that has been a stressor for Soldiers in other areas of the world, such as Iraq and Afghanistan. Nearly 45% of Soldiers felt they were 'making a direct contribution to the mission' and 'like the chance to help preserve the peace in this region', indicating that Soldiers do feel a sense of importance being in Korea and that the mission is clear to them. With the exception of 'I deal with stress better because of this tour' and 'I like interacting with KATUSA', Soldiers who agreed with these items were significantly less likely to meet screening criteria for a psychological health problem.

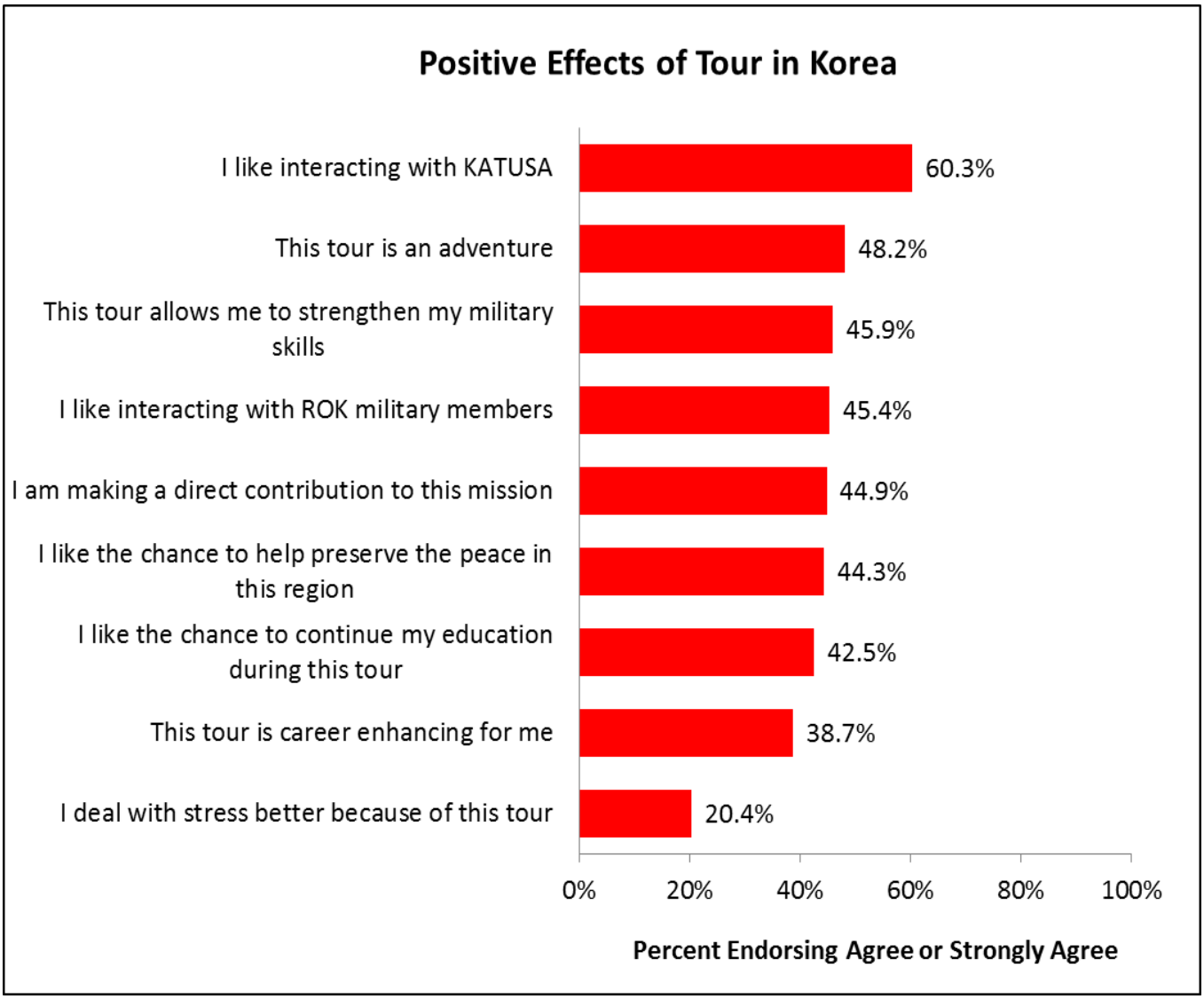


Figure 7.4. Positive effects of tour in Korea

7.5 Quality of Life

To examine the quality of life in Korea, we asked twelve questions about services and resources available in Korea and asked Soldiers to rate each statement from 'low' to 'high' (Appendix A, Question 62). The top two quality of life items receiving a high rating were Morale Welfare and Recreation (MWR) and Army Community Services, indicating that good resources are available for Soldiers to participate in activities outside of work. Only 25.4% and 28.8% of Soldiers gave living conditions and food a high rating, respectively, indicating that there is room for improvement for basic life support services. In general, quality of life ratings were lowest in Area I and highest in Area II, consistent with the variations in austerity in the regions of Korea, with Soldiers stationed in the city of Seoul having much greater access to and quality of services than those stationed near the border with North Korea.

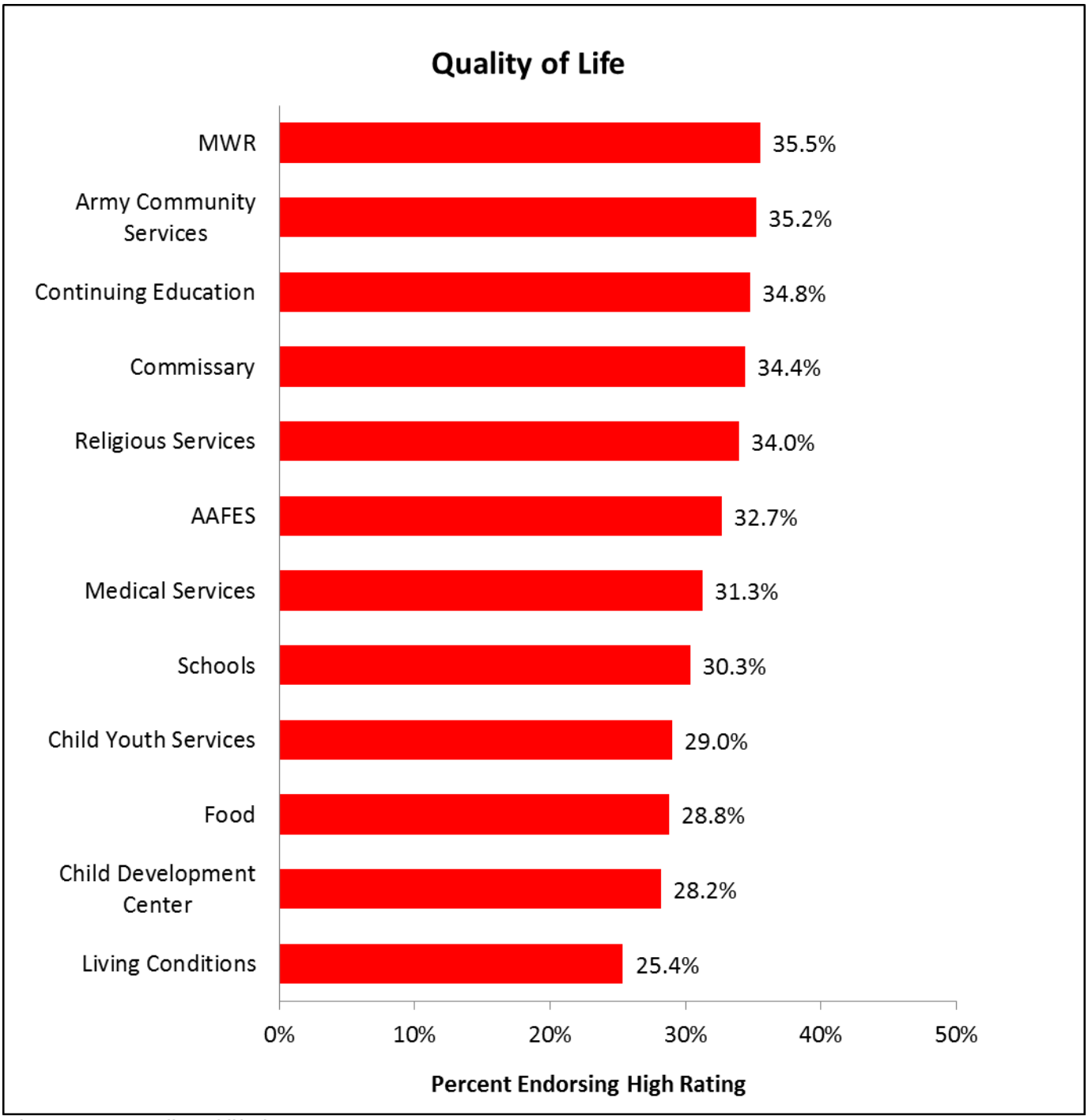


Figure 7.5. Quality of life in Korea

7.6 Behavioral Health Leadership

One mechanism through which leaders can influence Soldier adjustment is through behavioral health leadership, defined as a set of leader behaviors that emphasize support for the health of unit members. In a series of studies, WRAIR has found that Soldier ratings of their leadership on these behaviors accounts for Soldier well-being and unit climate above-and-beyond the contributions of generally good leadership. In this assessment we examined two forms of behavioral health leadership: operational stress control leadership and sleep leadership.

7.6.1 Operational Stress Control Leadership

We assessed the frequency that leaders and supervisors engage in operational stress control leadership behaviors with six items measuring the extent to which leaders encourage Soldiers to manage work and family stressors and seek help when needed (Appendix A, Question 59). These questions were developed from leader behaviors highlighted in Combat Operational Stress Control (COSC) doctrine and have been published elsewhere (Adler et al., 2014). Results from these questions are presented in Figure 7.6.1. Over half of the sample (53.3%) reported that their Platoon Sergeant 'Does not judge Soldiers who seek behavioral health help' either 'often' or 'always'. Close to half of the sample reported that their Platoon Sergeant 'often' or 'always' engages in other behaviors related to behavioral health, such as reminding Soldiers of the mission, encouraging behavioral health treatment, and intervening when Soldiers are displaying stress reactions. When summing across all of the items, Soldiers who reported their Platoon Sergeant as engaging in these behaviors 'often' or 'always' were 50% less likely to report barriers to seeking behavioral healthcare. This suggests that when leaders promote a positive behavioral health climate, their Soldiers are more knowledge and more likely to obtain treatment if needed.

Figure 7.6.1. Operational stress control leadership behaviors by Platoon Sergeants

7.6.2 Sleep Leadership

Figure 7.6.2 displays the results of nine questions used to assess the extent to which leaders engage in behaviors to encourage healthy sleep habits (Appendix A, Question 58). One third of Soldiers reported that their leaders encourgaged them to get enough sleep and worked to create work schedules and environments conducive to sleeping 'often' or 'always'. Individuals reporting that their leaders 'Encourage Soldiers to get enough sleep' 'often' or 'always' reported obtaining signficantly more sleep per night.

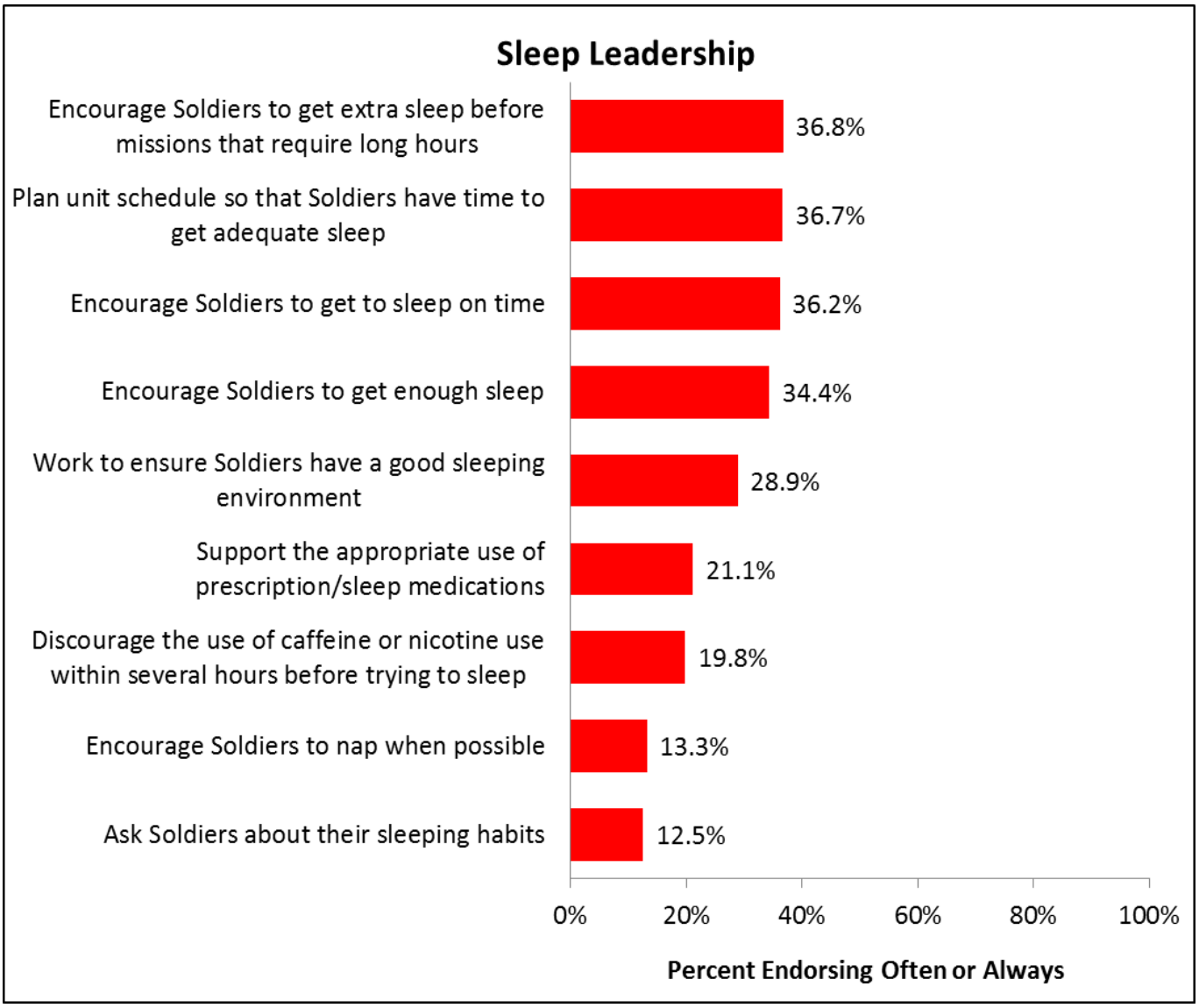


Figure 7.6.2. Sleep leadership behaviors by Platoon Sergeants

8 BEHAVIORAL HEALTHCARE SYSTEM

This section of the report presents findings from the assessment of the behavioral healthcare system in Korea using data derived from Soldier and Provider surveys, Soldier and Provider focus groups, data calls with Army medical units in Korea, and data provided by Regional Health Command-Pacific. Specifically, behavioral health utilization, telebehavioral health (TBH), behavioral health buddy care assistance, behavioral health staffing, and behavioral health staff perceptions of workload and other challenges were assessed.

8.1 Support Services

Despite the reports of barriers to seeking behavioral healthcare, 23% of the sample reported receiving behavioral health services in the past year. Figure 8.1 shows the percentage of Soldiers reporting seeking behavioral health treatment from each type of provider. Of those who reported seeking care, the top three behavioral health providers were: behavioral health professionals (52%), medical providers (other than BH providers) (47%), and chaplains (30%).

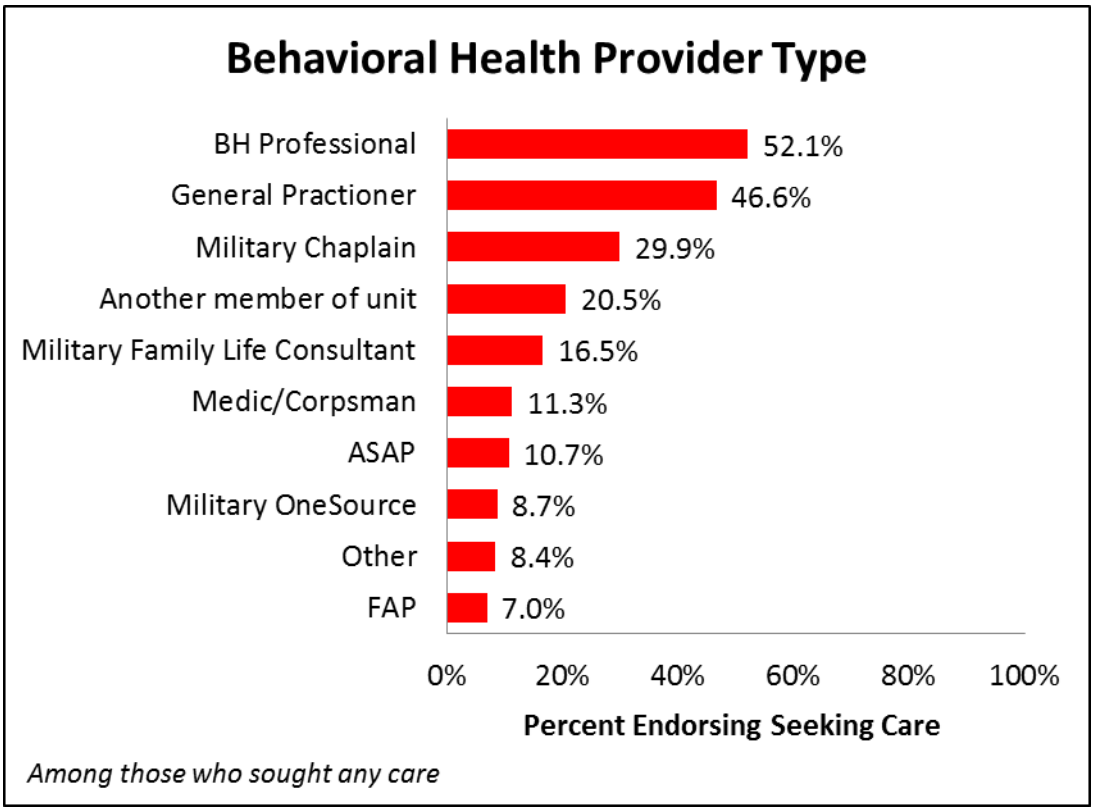


Figure 8.1. Supportive Services utilization by type

8.2 Telebehavioral Health (TBH)

Survey data found that 11 of the 54 behavioral health staff reported using TBH. Of the 11 who used it, eight felt that it was efficient and were comfortable discussing Soldier issues. In focus groups, providers generally agreed that telebehavioral health was a valuable, but underutilized, resource.

With regard to assessing TBH utilization, analyses by RHC-P found that while two clinics had the TBH capability, it was not fully utilized. For instance, data collected found that Providers only utilized TBH 65% of the time in one Area and 48% of the time in another Area. For both these clinics, TBH appointments

were scheduled more often than they were actual utilized. That is, while TBH appointments were scheduled, many were cancelled or postponed.

8.3 Behavioral Health 'Buddy Care' Competence

Table 8.3 presents data on the extent to which Soldiers feel they can identify mental health issues and assist fellow Soldiers in obtaining assistance (Appendix A, Question 61). Overall, nearly two-thirds of the Korea sample reported that they 'strongly agree' or 'agree' that they could identify a Service Member at risk for suicide and could assist another Service Member in obtaining mental health assistance. These estimates were similar to other samples, with slightly higher percentages reporting they were confident in their ability to help another Service Member get mental health assistance compared to CJTF-HOA (68.4% versus 62.1%). This may be due to differences in services provided in each environment (e.g., CJTF-HOA did not have a dedicated behavioral health provider), or due to differences between a population that is predominantly Active Duty versus one that is predominantly National Guard/Reserve.

Table 8.3. Percentage of Soldiers indicating confidence in their ability to support other Service members with Behavioral Health issues

Buddy Care Competence	Korea 2016	CJTF-HOA 2012	OEF 2012	OEF 2013
I am confident in my ability to identify Service Members at risk for suicide.	64.9%	61.8%	65.0%	65.2%
I am confident in my ability to help Service Members get mental health assistance.	68.4%	62.1%	70.7%	69.9%

Sample-adjusted values for rank and gender. Percent endorsing "Agree" or "Strongly Agree"

8.4 Behavioral Health Staffing

MHATs have historically assessed the Soldier/Provider ratio as a rudimentary indicator of whether or not the behavioral health needs of Soldiers are being met in a given area. For example, MHATs conducted in Iraq and Afghanistan reported this ratio as a snapshot of behavioral health staffing around the theaters of operation and it varied from 1,756:1 in Iraq in 2005 to 567:1 in Afghanistan in 2013, including both credentialed providers and technicians. Traditionally and in accordance with Army Medical Department guidance, the desired ratio of Soldier to Provider in theater has been within 800-1000:1; thus, this ratio has been seen as a set point for the number of Providers needed. Along with the number of Providers, the distribution of where the Providers were located in theater was just as important to account for, especially during combat deployments, since many Soldiers deployed to austere locations faced challenges in seeing a Provider due to difficulty in travel and kinetic operations.

Ratios of Soldiers to providers in a deployed environment should not be considered a guide for garrison or OCONUS locations, as there are many other factors that have to be considered, such as availability of behavioral health services in primary care, capacity for services in different clinics, standards for care for longer term treatment needs, the availability of care managers, the broader beneficiary population, and the need for specialized services not available in theater including inpatient, intensive outpatient, substance abuse rehabilitation, and family advocacy services. Given these differences, we will not report a staffing ratio of Soldier to Provider as in previous MHATs conducted in combat environments. We will utilize data routinely collected by MEDCOM in the Behavioral Health Service Line (BHSL) such as the Capacity Assessment Reporting Tool (CART) and the BHSL Matrix Tool. Both the CART and the Matrix Tools assess (with more granularity than a simple ratio of Soldier to provider), the staffing and workload data in a given garrison (CONUS or OCONUS) environment.

8.5 Army Beneficiary and Army Provider Populations in Korea

Table 8.5 below provides specifics on the Army beneficiary population in Korea. The population is comprised of Army active duty members, Army active duty family members, Army PLUS (generally the mechanism for Retirees residing in Korea), and KATUSA as illustrated in the table below (provided by the [redacted] Hospital and TRICARE Korea office). The total supported beneficiary population at the time of the assessment was [redacted]. At the time of the assessment there were [redacted] Army Behavioral Health Staff in Korea (including US Service Members, DA Civilians, and Contractors; does not include local national Korean civilians).

Table 8.5. Beneficiary Population in Korea

HRP		AD	ADFM	PLUS	KATUSA	Total Supported Population
Area I	Casey	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Red Cloud	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Stanley	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Area II	BAACH	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	YHC	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Area III	Humphreys	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Area IV	Walker	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
	Carroll	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Total		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: [redacted] *Combat Support Hospital and TRICARE Korea Office*

8.6 MEDCOM Staffing and Workload Metrics for Korea

MHAT-K8A partnered with Regional Health Command-Pacific (RHC-P) and the Office of the Surgeon General (OTSG), Behavioral Health Division in order to add current staffing metrics now routinely used throughout MEDCOM to the MHAT-K8A report.

Over the past ten years MEDCOM has developed, refined, and implemented a number of staffing and workload metrics particularly for garrison environments that were not previously included in MHAT Reports. These metrics provide real-time measurement and feedback to improve staffing efficiency and productivity across the healthcare enterprise.

Summarized Table 8.6a (below) are BHSL Distribution Matrix Tool (MATRIX) data on projected needs for Korea. MATRIX is a staffing tool/algorithm which yields an optimal staffing level given beneficiary demands and other factors. For Korea, during the time of the MHAT assessment, MATRIX yielded [redacted] Providers as the total needed to support beneficiaries in Korea breaking down into [redacted] Psychiatrists, [redacted] Psychologists/ Social Workers/Counselors, and [redacted] Supervisors. At the time of the report (and as noted above), there were [redacted] Army Providers ([redacted] in clinics and [redacted] Behavioral Health Officers (BHO) in the Brigades). Thus, the MATRIX yielded a staffing fill rate of [redacted] ([redacted]; taking into account BHO augmented support) or [redacted]% fill rate ([redacted]; using clinical positions only). When the MHAT-K8A team inquired with OTSG about enterprise level shortages, a representative agreed that staffing was a challenge in many places and that MEDCOM had about [redacted] providers on hand of the [redacted] required to

meet the enrolled population's clinical demand. This translates to a fill rate of [redacted] not including Providers assigned to FORSCOM, USARPAC, USAEUR or USASOC.

Table 8.6a. MATRIX staffing data for Korea

DMIS ID	DMIS Name	Provider Type	Totals	DBH	Sub-Chief Additive	Subchief	Total Providers	On Hand
0612 (P)	KORE Rollup	Psychiatry / MP					[redacted]	[redacted]
		Psychology					[redacted]	[redacted]
		SW / LPC / LMFT						
		Total Providers	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: Regional Health Command-Pacific

In addition to staffing needs, current metrics allow for the assessment of productivity. The Capacity Assessment Reporting Tool (CART) application is a program that tracks Relative Value Units (RVUs) and Provider numbers by area. The CART is a monthly MEDCOM-developed tool that assists leaders in managing availability and production at all levels (MEDCOM, Regional, MTF, clinic, and provider). Production is measured in provider aggregate (PA) work RVUs and is displayed in a manner that can be extracted and reported at each of the levels mentioned. Availability is measured in full-time equivalents (FTEs). In addition to clinic availability, other areas such as training, prevention and health promotion, readiness, and clinic administration are included to allow leaders to see where providers are reporting their time.

The signature workload demand indicated by CART is the most significant driver used for staffing along with specific program requirements and the beneficiary population. These indicators influence the staffing MATRIX and are used by the BHSL. The MATRIX allows the BHSL to annually modify staffing needs based upon workload demands versus the more antiquated three year TDA projection previously used. For example the table above indicates that Korea has earned a total staff of [redacted] providers. Of the [redacted] is the Director of BH, [redacted] are Sub-Chiefs, and [redacted] are providers. The number [redacted] is not to be rounded up given that the Addiction Medicine Intensive Outpatient Program earned [redacted] of a provider as a program requirement. In addition, the Sub-Chief column indicates production discount on the CART for four designated Sub-Chiefs. It does not indicate an additional four members.

Table 8.6b. Capacity Assessment Reporting Tool (CART) data for Korea by area

CART November Report February

Summary

KOR	Sum of PA_RVU Δ	Sum of People Included
Area I	(2657.87)	[redacted]
Area II	3118.42	[redacted]
Area III	(7823.34)	[redacted]
Area IV	(6380.55)	[redacted]
Grand Total	(13743.34)	[redacted]

Source: Regional Health Command-Pacific

The table above indicates the total of all providers dispersed throughout Korea. The providers are held to a MEDCOM set standard (each specialty is different) which is then subtracted to get the delta (Provider PA_RVU – MEDCOM standard = Delta). The current MEDCOM standard is set on a rolling twelve months. From that, the delta is rolled up into an area to get the table numbers. As with any metric, data

must be current and attention paid to input in order for it yield timely and valid data. As such, it is incumbent on each MTF to adequately and routinely populate CART using the DMHRSi data input. A monthly review of the CART is hosted by RHC-P allowing the MTFs in Korea to discuss concerns and corrections made regarding data accuracy and discrepancies as well as explanations for individual provider productivity.

The role and use of Behavioral Health Officers assigned to Brigades was also mentioned frequently by providers in theater and in our interactions with RHC-P leadership. Behavioral Health Officers (BHOs) play a vital role within the operational Army. BHOs are specifically assigned to Brigades and act as advisors and consultants to Brigade and Division leadership on all matters of behavioral health and make recommendations—or actually enact the means--to sustain or improve behavioral health across the unit. BHOs are also relied upon for their clinical skills and to provide behavioral healthcare within their unit. In Korea, a BHO is expected to have 50% of their time devoted to the clinical aspect of their role. In talking with medical leadership in Korea and at RHC-P, maintaining proper clinical documentation of their 50% clinical duties and synchronizing with the local clinics is a challenge. BHO communication and synchronization with Korea clinics is an important factor in behavioral health care on the peninsula. Ensuring that BHOs use the tools clinic personnel routinely use to quantify workload, effort, and patient encounters will help to provide a better assessment of the totality of behavioral health support in Korea.

8.7 Perceptions of Staffing Challenges: Survey and Focus Group Data

In order to further assess perceptions of staffing, workload, morale, and burnout, a survey was fielded with behavioral health staff in Korea. Of the [redacted] behavioral health staff reported to be in Korea during the time of the assessment, [redacted] of them completed the survey for a participation rate of 68%. Table 8.7a summarizes perceptions of staffing and backfill support. Overall, only 12 percent of providers felt there were sufficient behavioral health assets in Korea and nearly 60% felt that the high rates of turnover negatively impacted their clinic. One-third of providers reported having backfill support to meet the needs of their clinic and of those, 90% felt this support was helpful.

Table 8.7a. Provider perceptions of staffing and backfill support

Backfill Program	Korea 2016
Felt there were sufficient BH assets in Korea	12.0%
Felt high turnover negativly impacted their clinic	59.0%
Used backfill to meet program requirements	32.0%
Felt backfill was helpful*	90.0%

Percentage Endorsing "Yes"
** Of those using backfill*

Table 8.7b summarizes behavioral health Providers ratings of burnout, compassion satisfaction, team, and individual morale compared to providers in OEF 2013. Findings indicate similar ratings of burnout, compassion satisfaction, and individual morale, but indicates that the percentage of providers rating behavioral health team morale as high was significantly higher in Korea (32%), compared to OEF 2013 (8%).

Table 8.7b. Provider burnout, compassion satisfaction, and individual and team morale

	Korea 2016	OEF Medical Staff 2013
Provider Burnout	2.53	2.49
Compassion Satisfaction	4.04	3.78
Individual Morale	59.6%	44.4%
BH Team Morale	32.7%	8.3%

Provider Burnout - Higher scores indicate more burnout on a scale of 1-7
Compassion Satisfaction - Higher scores indicate more satisfaction on a scale of 1-5
Percent endorsing "High" or "Very High"

From the focus groups conducted with Behavioral Health Providers, a general theme related to staffing and workload pertained to the use of ancillary support and existing resources in the clinics. Many Behavioral Health Providers expressed a desire to more fully utilize 68X technicians in their clinical duties in order to augment patient care. Many reported that 68Xs often become de facto administrative 'front desk' personnel since there are often shortages in hiring support staff. More clinical focus from 68Xs would make the clinical support more robust around the clinics, and is in line with OTSG/MEDCOM Policy Memo 15-041, which indicates that 68Xs must maintain competency in the full scope of clinical skills and be utilized to support clinical care under the supervision of licensed providers.

Relatedly, clinics reported the need for stable administrative support to help balance workload requirements and to allow 68Xs to focus a greater percentage of their time on clinical duties. Another common theme among the focus groups was delays in new hires, whether DA civilians or contractors. Each was discussed as difficult. For DA Civilians, a lengthy administrative hiring process sometimes meant that potential applicants or selectees pursued other options. For contractors, finding and maintaining qualified personnel via a contract mechanism was also a challenge due to cultural differences and geographical distance from the US.

The staffing of counselors in IMCOM's Army Substance Abuse Program staffing was also noted by providers in focus groups as well as by RHC-P's analysis of staffing. Specifically, a number of vacancies were reported that place a strain on offering alcohol or substance abuse support to Soldiers. In fact, each of the four Areas in Korea reported staffing problems. One possible explanation for the shortages mentioned by focus group participant is that the Department of Army civilian position as a Counselor/Provider is set at the GS-11 level. Historically the program has been able to fill these positions; however, other behavioral health positions at GS-12 level and higher often become available in Korea. Consequently, some of the ASAP Providers have left the program to take GS-12 and higher positions in Korea and creating lingering vacancies in a widely-used and needed program. This issue was also something that RHC-P was tracking in our discussions with them.

With regard to frequent turnover (noted above from survey data), many Providers who took part in the focus groups expressed concern with the frequent turnover of personnel and relatively short tours of duty (compared to a typical CONUS tour) in Korea. They felt that the frequent turnover had an effect on the continuity of the mission—the hand-off of caseload from Provider to Provider; the hand-off of supervisory

duties from Chief to Chief; and the challenges of building a therapeutic alliance with patients in a healthcare environment that was so dynamic.

In summarizing behavioral health provider and staff data collected through survey and focus groups as well as by the CART and BHSL Matrix Tools, there was ultimately a high degree of concordance between recommendations advocated for by RHC-P after scrutinizing their data and from the MHAT-K8A team from survey and focus group data. Specifically, both assessments recommended that telebehavioral health should be more broadly fielded and utilized. Both assessments noted the role of the Behavioral Health Officer needed to be leveraged; both assessments called for more of a role for 68Xs utilization in the clinical realm, and; lastly both assessments noted that there were significant hiring impediments (whether DA Civilian or contractor) that needed to be overcome to better support the behavioral health needs in Korea.

9 SOLDIER FOCUS GROUP SUMMARY

Soldier focus groups addressed the following topics: 1) Quality of Life, 2) Transition to Korea, 3) The Mission, 4) Morale and Leadership, 5) Social Relationships, 6) Alcohol, 7) Behavioral Healthcare 8) Suicide, and 9) Coping.

The MHAT-K8A team conducted 14 focus groups with a total of 87 Soldiers (7 focus groups with junior enlisted Soldiers (E1-E4, n=44), and 7 focus groups with NCOs (E5 to E8, n=43)) from all four regional areas within Korea to include 2 focus groups with the rotational unit in Area I. MHAT-K8A team members met with maneuver and support unit Soldiers at Camp Red Cloud (Area I), Camp Casey (Area I), Yongsan Garrison (Area II), Camp Humphreys (Area III), and Camp Carroll (Area IV).

Focus group sessions were conducted separately for junior enlisted Soldiers and NCOs. Participant identities were kept anonymous and participants were informed of the confidential nature of the focus groups. Sessions ranged in duration from 1-2 hours, with the average session taking approximately 90 minutes.

1) Quality of Life

The quality of life stressors that Soldiers reported centered around issues that affected their lives off duty, such as poor living conditions and the unique Army policies that are in place in Korea. Both junior enlisted Soldiers and NCOs often stated that barracks were over-crowded and in a state of disrepair. There were several reports of 'black mold' and poor Directorate of Public Works (DPW) service; this was brought to the attention of the USFK Surgeon's cell. Soldiers seemed to understand the rationale for the policies in Korea, such as the strict curfew and requirement to have a battle buddy present at all times, but they felt that policies were overly restrictive, negatively impacted morale, and caused a lack of separation between on- and off-duty hours.

2) Transitions to Korea

Soldiers reported little or no contact with anyone from their receiving unit prior to arriving in Korea. Only individuals who were accompanied by their families consistently reported having received any form of sponsorship. Many Soldiers reported not knowing where in Korea they would be stationed until after they arrived, and felt distressed by this lack of certainty. Soldiers reported mixed experiences with in-processing, which was highly dependent on the individual unit. Soldiers who reported having a poor in-processing experience often noted that there was insufficient Korean cultural awareness training or exposure to the Korean economy. These issues particularly impacted junior enlisted Soldiers reporting to Korea directly from AIT, who had never in-processed before and received little guidance from USFK MHRD prior to arrival.

3) The Mission

Soldiers seemed to be split on their perception of the importance of their mission in Korea. Several reported that they felt they were not needed in Korea, and that the Korean Army was capable of defending attacks from North Korea on their own. Some junior enlisted Soldiers reported understanding the importance of the mission to evacuate civilians, but felt inadequately prepared and equipped to meet mission demands. Compared to their junior enlisted counterparts, NCOs were more informed about the mission and the importance being conveyed by senior leaders. However, NCOs questioned the actual importance of the mission and their readiness to accomplish the mission if required.

4) Morale and Leadership

Morale varied significantly across units, and appeared to be highly dependent on leadership. NCOs appeared to be most impacted by Company and Battalion level leadership, while junior enlisted felt a greater impact from Platoon and Company level leadership. Junior enlisted reported higher levels of morale and often reported greater involvement in training and daily tasks. Those reporting low morale

also reported having leadership that “led from the rear” and did not engage with Soldiers on a daily basis.

5) Social Relationships

Soldiers did not report any difficulties communicating with family members or friends from home, other than the inconvenience of the time difference. Soldiers reported social media as the primary method of communication. Soldiers reported that social isolation was more of an issue in Korea than CONUS because of the strict policies that are specific to Korea. NCOs primarily discussed overly strict fraternization standards that placed constraints on individuals with few peers of similar rank, and the issue was exacerbated by the high turn-over rate of personnel. Junior enlisted Soldiers stated that the myriad of strict policies often discourage them from leaving post or their barracks. Soldiers also mentioned that programs such as MWR and BOSS offered opportunities to travel and meet other people. The awareness of these programs seemed to be highly dependent on location (e.g., Area II reported more awareness of the programs and Area IV less awareness). Although Soldiers expressed a desire to participate, actual participation rates were low due to space availability, lack of prior planning, and lack of financial resources. Soldiers also stated that intermural sports programs encouraged them to be active, socialize, and fostered unit cohesion.

6) Alcohol

Soldiers stated that drinking created more issues in Korea than at other duty stations for several reasons: (1) Soldiers reported that Korean culture influences drinking habits and that on-post restrictions - primarily restrictive barracks policies - encourage Soldiers to go off-post to drink; (2)Soldiers also reported that the frequent implementation of General Order #1 (abstaining from alcohol and other restrictions) causes Soldiers to develop binge drinking habits; (3) many also reported that curfew exacerbates drinking problems because they feel the need to drink faster in order to get back on post in time. NCOs stated that underage drinking was also an issue due to the lack of “carding off post.”

6.1) Alcohol and Substance Abuse Program (ASAP)

Many Soldiers reported that ASAP is misused by Command, who treat it as a form of punishment rather than a resource for individuals that need help. For example, even non-drinking related curfew violations frequently resulted in command-directed referrals to ASAP. Soldiers were split on the effectiveness of the program. It seemed to be highly dependent on the installation whether it was viewed as helpful or not. Soldiers who had been enrolled in ASAP stated that the largest issue with the program was the language and cultural barriers with Korean counselors.

7) Behavioral Healthcare

While most Soldiers reported that their command was supportive of and encouraged the use of behavioral health services, Soldiers expressed concerns of command being overly involved in the process and interfering with treatment (e.g. feeling a lack of privacy and confidentiality). Soldiers reported very little stigma associated with receiving behavioral healthcare; however there were groups of Soldiers who viewed receiving behavioral health treatment as detrimental to their careers. There was also a large portion of Soldiers who lacked behavioral health literacy. Specifically, Soldiers did not know where to go to get help if they needed it and were unaware of the consequences of receiving treatment. Soldiers expressed a desire to have better understanding of confidentiality rights and how receiving behavioral health treatment could influence career progression, including school applications, security clearances, and promotions.

8) Suicide

Suicide was generally not perceived to be any more of an issue in Korea compared to other duty locations. Most Soldiers reported that they felt adequately prepared to help their fellow Soldiers.

9) Coping

Most Soldiers reported alcohol use, exercise, and sleep as the primary forms of coping with stress and boredom. Soldiers felt that alcohol use as a coping mechanism was greater in Korea than in other duty locations, due to higher levels of stress and separation from family. However, Soldiers who had their families with them in Korea often reported spending time with them as their primary coping mechanism. Soldiers also reporting exercising and going to the gym as ways of alleviating boredom and coping with stress.

10 BEHAVIORAL HEALTH PROVIDER FOCUS GROUP SUMMARY

Behavioral Health Provider (BHP) focus groups addressed the following topics: 1) General Korea Behavioral Health Support 2) Suicide-related Issues 3) Alcohol and Substance Abuse 4) Return to Duty 5) Resources 6) Treatment: Engagement, Adherence, and Adaption 7) Working Behavioral Health Mission with Others 8) Behavioral Health Provider Well-Being 9) Command Relationships and 10) Tele-behavioral Health.

The MHAT Korea team conducted 4 focus groups with a total of 19 Behavioral Health Providers (Officers n=10, Contractors n=3, DA Civilians n=5, and one non-appropriated fund (NAF) employee. Focus groups were conducted in all 4 regional areas within Korean including Camp Casey (Area I), Yongsan Garrison (Area II), Camp Humphreys (Area III), and Camp Walker (Area IV).

Participant identities were kept anonymous and participants were informed of the confidential nature of the focus groups. Sessions ranged in duration from 1-2 hours, with the average session taking approximately 90 minutes.

1) General Korea Behavioral Health Support

BHPs reported that the most common problems that Service Members are seeking care for in Korea were: adjustment issues (particularly for junior enlisted and especially those new to the Army), family/marital issues, which may be exacerbated due to lack of command sponsorship and long distance; PTSD from previous deployments; alcohol abuse; command climate, uncertainty of a unit's deployment/garrison status; and suicidal ideation. Unique issues specific to Korea included difficulties in maintaining social support due to frequent PCSing; frequent rule changes due to changing commands; and culture shock.

2) Suicide-related Issues

BHPs stated that they frequently saw patients for suicidal ideation. Some providers reported an influx of high risk patients including those with borderline personality symptoms. BHPs stated that the drivers of suicidal ideation/behaviors were isolation, lack of support from Soldiers' chain of command, and the strict rules in Korea that were difficult for junior Soldiers to adjust to during their first tour.

In terms of suicide prevention, BHPs explained that the current system was not very effective and was suffering due to a lack of sufficient staffing. BHPs relied heavily on ASAP, quarterly trainings, Chaplains, Suicide Response Teams, and the occasional suicide stand down day. Multiple BHPs described the current system as a "check the box" training requirement that was not a priority for the chain of command. BHP recommendations included using hotlines, providing good leadership, having behavioral health resources presented in newcomer's briefs, and allowing BHPs to do prevention training.

3) Alcohol and Substance Abuse

BHPs reported that half of their patients had either alcohol misuse as their primary behavioral health problem or as a comorbid symptom with another behavioral health problem. BHPs reported that the drivers of alcohol/substance abuse were the drinking culture, potency of soju (a traditional Korean alcoholic beverage), and underage Soldiers being able to access alcohol due to the lack of "carding" in the community. BHPs also stated that excessive drinking leads to many Service Members missing curfew. BHPs reported that many Service Members needed to be enrolled in ASAP, but that the program is understaffed and had a long waiting list. BHPs recommended that ASAP should increase staff, reduce turnover, and utilized ALTHA in its documentation.

BHPs stated that alcohol/substance misuse prevention training was not effective and that ASAP seems to be more focused on administrative issues (e.g., curfew violations) rather than clinical issues. BHPs stated that leadership could reduce alcohol related behaviors by focusing on empowering young soldiers to be responsible, slowing the OPTEMPO, investing in team building, and emphasizing mentorship.

4) Return to Duty

In terms of RTD decisions, BHPs frequently questioned whether they had sufficient resources in Korea and suggested solutions such as Service Member curtailments back to the US, transferring Service Members to Warrior Transition Units, considering medical discharges, and being cognizant of when to restrict a Service Member's access to weapons. The major obstacle in making RTD decisions seemed to be the lack of resources, especially personnel. BHPs reported that they did not have sufficient training on making RTD decisions and, for the most part, had to rely on their clinical judgment. In terms of risk aversion affecting RTD decisions, some BHPs were more cautious depending on the MOS of their patient, especially with Military Police and aviation personnel. BHPs also stated that many company commanders are reluctant to take their Soldiers back and second guess the provider on their RTD decision.

5) Resources

BHPs reported lack of staffing and staff turnover as significant problems. On the military side, providers are on a one year rotation. BHPs reported that they needed more staffing and that burnout is a problem. BHPs stated that it was very difficult to provide behavioral health support to everyone in their area of responsibility, leading to the need to reduce the patient population to military personnel only, excluding dependents and civilians. BHPs reported 4-5 week intervals for follow up appointments and being backed up during the holidays. Lack of adequate space was a problem for most providers. When asked what resources they needed to better support their patient population, the BHPs reported that additional staff was the primary need, followed by psychological assessment tools, furniture, and computers.

BHPs reported that the role of Behavioral Health Technicians (68X) was to perform patient intakes, triage, psycho-education, and man the front desk. Some BHPs described 68Xs as being extremely underutilized and employed primarily for administrative duties.

6) Treatment: Engagement, Adherence, and Adaption

To ensure treatment engagement, BHPs performed safety checks with their assigned technicians and checked in on patients that cancelled appointments. In order to accommodate issues specific to Korea, BHPs would encourage the use of therapy groups. To supplement standard behavioral health treatment, BHPs offered classes to Service Members on coping skills and anger management. BHPs suggested using public service announcements to advertise where behavioral health resources were located and how to access behavioral healthcare.

7) Working Behavioral Health Mission with Others

BHPs reported that they did not have much time to interact with other behavioral health providers, but when time permitted, they would mainly discuss high risk patients. BHPs also stated that they did not have much interaction with chaplains, but utilized them for religious and marital issues. BHPs reported that they frequently coordinated with medical providers for prescription needs and collaborative care, and also engaged with nurse case managers and other providers at standardized events such as Community Health Promotion Councils.

8) Behavioral Health Provider Well-Being

Morale among BHPs varied from person to person depending on the degree of support that the provider was receiving from leadership and/or the amount of staffing in the clinic. The number one stressor for BHPs was insufficient manpower and the inability to get additional support. BHPs also

stated that they would benefit from having counselors for themselves in order to combat patient transference. Burnout was often cited as a concern among providers. In order to ameliorate burnout, BHPs reported engaging in yoga and attempting to increase the number of providers in their clinics.

9) Command Relationships

Command relationships varied from provider to provider. Some reported having good relationships with leadership and had frequent communication while others reported a non-existent relationship until safety issues or other problems arose. Problems that BHPs reported with leadership consisted of commanders not understanding how the system worked, overusing command directed referrals, and variability in providing access to care.

10) Tele-behavioral health

There was high variability between clinics in terms of TBH accessibility. BHPs who had access to TBH reported using it for school evaluations, medication consultation, and coordination of services with Tripler Army Medical Center. Most providers were content with the TBH backfill support provided by Tripler. Some BHPs reported an advantage for Service Members using TBH, especially for supporting medication management, and explained that younger individuals seem to be more open to using this technology. The main challenge to using TBH was lack of space, coordination of care, and the need to have an additional Service Member available in case of safety issues or suicidal ideation.

11 RECOMMENDATIONS

Generally speaking, the estimates of behavioral health problems reported by Soldiers were relatively low compared to other MHAT data comparisons. Estimates of concern with stigma and barriers to receiving behavioral healthcare were lower than all MHAT comparisons. Soldiers in Korea rated favorably compared to MHATs conducted during combat operations and in many instances Soldiers in Korea also rated favorably compared to behavioral health data collected in the Horn of Africa and from another large USAEUR-based (OCONUS) unit. As such, the focus of the recommendations provided below are on the identification and mitigation of relative risk factors and enhancing factors protective of Soldier behavioral health.

11.1 Optimizing Behavioral Health Staffing (Proponents: MEDCOM, FORSCOM, IMCOM)

As noted in the section on behavioral staff, the MHAT-K8A team collected survey and focus group data to learn about Provider perceptions of behavioral health staffing in Korea. The MHAT-K8A team also collaborated with RHC-P and OTSG Behavioral Health Division in order to provide data routinely collected in the healthcare commands on staffing needs and workload. The recommendations below are based on both MHAT-K8A and RHC-P data sources.

- Ensure that MTF personnel optimize data input for CART and MATRIX staff and productivity measurement

CART tracks provider productivity at Medical Treatment Facilities (MTFs) and includes Behavioral Health Officers (assigned to Brigades). In order for the tool to provide valid, real-time data and feedback to MEDCOM, provider data must be routinely updated to provide an accurate snapshot of MTF productivity. If this is not done, the risk is that the productivity numbers generated by CART may be based on older data that is not an accurate reflection of current staff or RVUs.

MATRIX is a MEDCOM tool used to calculate the optimal number of Providers needed given the beneficiary population, clinical caseload, and other considerations. MTFs must ensure that they synchronize provider schedules against access to care standards for Korea. Moreover, once an optimal number of providers is determined using the MATRIX tool, MTFs must ensure that personnel are correctly aligned against these needs (e.g., MATRIX data).

- **Continue backfill support to clinics in Korea; pursue and leverage other support opportunities**

MEDCOM, and specifically RHC-P and Tripler Army Medical Center, have historically provided backfill Provider support to Army clinics in Korea. Providers reported in MHAT-K8A surveys that this capability was greatly valued and helped ease the clinical workload. Although not a long-term solution, MEDCOM should continue backfill provider support when the need arises. Given the geographic distance and challenges identifying providers to backfill clinics in Korea, MEDCOM should seek to leverage other uniformed providers from across MEDCOM and with other DOD and governmental partners such as Public Health Service as a way to augment provider capacity in Korea. Medical leaders in Korea should pursue robust contracting mechanisms to help them attract, recruit, and retain contracted Providers from CONUS to work on the peninsula.

- Fully utilize telebehavioral health capability

Almost universally, Providers in focus groups indicated that the ability to conduct some of their clinical duties using telebehavioral health (TBH) was an enabler. Providers also reported that this type of support was a nice option not only with patients but also for consults with other medical providers. Ensure TBH

equipment is installed and functioning and that a TBH appointment schedule is routinely maintained. Pursue other aspects of behavioral healthcare that could be supported using TBH.

- Fully utilize clinic staff to serve as mission enablers: 68X, Administrative Support

68Xs, behavioral health technicians, are trained to conduct intakes, behavioral health training, and even some forms of therapy. However, in many instances it was reported that 68Xs did not routinely use their clinical skills. Instead, many served as administrative support and ran 'front desk' aspects of clinics. While using 68Xs administratively is often borne from necessity, medical leaders should involve 68Xs in clinical support as much as possible. In this way they serve as mission enablers and can help relieve the burden on Provider's workload.

Relatedly, behavioral health clinics should hire support staff (front desk or administrative assistants) up to the levels in the MATRIX. Those personnel can cover the entirety of the administrative aspects of running clinics. This would free up 68Xs to attend to their clinical duties.

- Ensure the Behavioral Health Officer (BHO) positions in the Brigades are fully-staffed and clinical duties routinely and continually documented

BHOs are on the front-line with the Soldiers of the units they support and as such, are proximal to providing expedient care. Ensuring that BHOs are fully integrated with local clinics and are documenting their caseload is another mission enabler. Documenting BHO clinical work is also critical for medical planners and leaders to understand the entirety of behavioral health support across Korea.

- Adjust Army Substance Abuse Program Counselor grade level.

From discussions with behavioral health leaders and from focus groups, many of the other behavioral health Provider/Ancillary Support positions were staffed at the GS-12 level, which meant that when one of these came open, GS-11s working in ASAP often pursued the higher grade position leaving a vacancy in ASAP. IMCOM should considering increasing the grade of the ASAP Counselor/Provider position from a GS-11 to a GS-12 position in order to help stem the attrition and lingering vacancies. In addition, the treatment component of the ASAP program is scheduled to transition to the MEDCOM BHSL in the fall of 2016, at which point MEDCOM may adjust the position. This may help maintain a much needed service for Soldiers and Leaders in Korea.

11.2 Identifying and Supporting At-Risk Groups (Proponents: 8th Army, TRADOC, G1)

- Ensure behavioral health prevention and outreach efforts for all in-bound personnel occur soon after arriving in Korea: focus on junior enlisted and new accessions throughout Korea.

Along with the standard psychological screening that occurs as part of unit-level Soldier Readiness Programs and Periodic Health Assessments (time-driven or around the deployment cycle), prevention and outreach should target at-risk Soldiers and groups as soon as possible after arriving in Korea. Elsewhere in the report the junior enlisted cohort was noted as being over-strengthed in Korea and was also known to be the biggest user of the BHSL in Korea. behavioral health leaders in Korea attributed the majority of patient encounters with junior enlisted as first term adjustment problems (not necessarily disorders). Targeting this cohort with prevention and outreach in the form of training and leader engagement/awareness would be beneficial. Adjustment problems are common in this group and that is likely not unique to Korea, however, being in Korea—what can be construed as socially and culturally isolated to some extent—may have an added deleterious effect.

- Focus on Soldiers with the following key risk factors: social isolation, financial difficulties, recent relationship problems, recent UCMJ actions

MHAT-K8A survey results identified that Soldiers who were socially isolated, having financial difficulties, having relationship problems or recent failures in relationships, or experiencing UCMJ-related problems were at significant risk for behavioral health problems to include suicidal ideation, alcohol misuse, depression, and anxiety. This is entirely consistent with data from other CONUS and deployment behavioral health assessments. Leaders and fellow Soldiers should be trained about these risk factors so that they can identify potential problems when they arise. Moreover, training should highlight risk factors such as these as potential warning signs that there may perhaps be a larger problem that could manifest negatively on a fellow Soldiers behavioral health. Existing training support may be available through the Army Resilience Directorate or through the IMCOM.

11.3 Optimizing Resilience in Units (Proponents: 8th Army, IMCOM)

-Emphasize social and team-building activities during off-duty time and especially over holidays to combat social isolation and subsequent effects on behavioral health

The overall prevalence of alcohol misuse was 28% as assessed with the MHAT-K8A survey; this was comparable to other CONUS assessments and was lower than the USAREUR-based assessment mentioned as a comparison in the report. Nonetheless, over 1 in 4 Soldiers screened positive for alcohol use using a clinically validated scale. Moreover, problems stemming from alcohol misuse in Korea were often mentioned by providers and Soldiers. In the Provider and Soldier focus groups, a consistent recommendation made to help overcome unhealthy drinking patterns among Soldiers in Korea, was to better emphasize social activities as a way of forming a team identity not involving alcohol or ‘going to the Ville’. From the Providers’ perspective, many of the Soldiers they treat would benefit from social involvement with the unit in healthier contexts such as team-building/bonding events including Better Opportunities for Single Solder events, intramural sports, USO trips and tours, and outdoor recreation activities. Although these programs exist, participation waxes and wanes. Soldiers and Providers alike noted that social activities could be more prominently advertised. And junior leaders can play a more prominent role in encouraging healthier social behaviors among their Soldiers. Belonging to a social group can help maintain a social contract and identity outside of work and may offset the risk of falling into unhealthy drinking patterns. Conversely, belonging to a social group where unhealthy drinking is the norm can also from a social contract of sorts that is problematic. Providers specifically singled out a common scenario where Soldiers have ‘nothing to do’ on a 4-day weekend or longer holiday time period. As indicated in Figure 5.4.3, 21% of the sample reported using alcohol to deal with boredom. Engaging local leaders and enhancing healthy social connection opportunities, especially during holidays, can help mitigate unhealthy behaviors (such as alcohol misuse) and unintended discipline or UCMJ problems.

- Review sponsorship programs for in-bound personnel

Sponsorship for in-bound and newly arriving personnel in Korea was mentioned in Soldier focus groups as an area of concern. Soldiers expressed the need for a sponsor to be engaged with them early on ahead of their assignment and throughout their in-processing. Logistically, this is challenging in Korea since many Soldiers, particularly junior Soldiers are not on pin-point assignment orders. Consequently, they do not know where they will be stationed in Korea until they arrive in Yongsan Garrison in Seoul. Since this was a common theme among Soldiers we spoke with, we recommend that units (perhaps with assistance from IMCOM) review their command sponsorship processes to see if there can be better communication and facilitation from the time a Soldier appears on a gains roster until they are integrated at their specific duty station in Korea.

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13 APPENDIX A: SOLDIER SURVEY

(begins on next page)

Republic of Korea (ROK) Soldier Well-Being Survey

WRAIR #2291
v2 21Dec15

DATE		
MONTH	DAY	YEAR
1 Jan		
2 Feb		
3 Mar	0 0	0 0 0 0
4 Apr	1 1	1 1 1 1
5 May	2 2	2 2 2 2
6 June	3 3	3 3 3 3
7 July	4	4 4 4 4
8 Aug	5	5 5 5 5
9 Sept	6	6 6 6 6
10 Oct	7	7 7 7 7
11 Nov	8	8 8 8 8
12 Dec	9	9 9 9 9

What is your current unit?

Division: _____

Brigade/Regiment: _____

Battalion _____

Company/Battery/Troop: _____

Platoon: _____

I RECEIVED AN INFORMATION SHEET AND I AGREE TO ALLOW MY SURVEY RESPONSES TO BE USED FOR RESEARCH PURPOSES.

0 **NO**
1 **YES**

A. DEMOGRAPHICS - This section asks for you basic demographic information.

1. AGE
   1 18-24
   2 25-29
   3 30-39
   4 40 or older

2. GENDER
   1 Male
   2 Female

3. GRADE/RANK
   1 E1-E3
   2 E4
   3 E5-E9
   4 Officer/Warrant Officer

4. Highest level of **CIVILIAN EDUCATION**
   1 Some High School
   2 High School Diploma/GED
   3 Some College/Associate's Degree
   4 Bachelor's Degree
   5 Graduate Degree

5. PRIMARY COMPONENT
   1 Active
   2 Reserve
   3 National Guard

6. How many **YEARS** have you been in the military? If less than 1 year, please mark "00".
   0 0 0 0
   1 1 1 1
   2 2 2 2
   3 3 3 3
   4 4 4 4
   5 5
   6 6
   7 7
   8 8
   9 9

7. For **THIS** tour, please indicate **MONTH/YEAR** you arrived in the ROK.

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1	2	3	4	5	6	7	8	9	10	11	12

Year	Prior to 2013	2013	2014	2015	2016
	1	2	3	4	5

8. For **THIS** tour, please indicate **MONTH/YEAR** you **EXPECT TO LEAVE** the ROK:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1	2	3	4	5	6	7	8	9	10	11	12

Year	2016	2017	2018	2019
	1	2	3	4

[Serial #]

9. What is your primary job/occupation during this tour?

① Combat Arms (such as IN, AR, CAB, FA, EN)
② Medical (such as Medic, X-ray Tech, Nurse, MSC)
③ Non-Medical Support and Sustainment (such as BSB, STB, MP, MI)

10. Where are you currently stationed?

Area I
① Camp Casey
② Camp Red Cloud
③ Camp Stanley
④ Other _____

Area II
⑤ Yongsan Garrison
⑥ K16 AB
⑦ Other _____

Area III
⑧ Camp Humphreys
⑨ Osan AB
⑩ Suwon AB
⑪ Other _____

Area IV
⑫ Camp Walker
⑬ Camp Henry
⑭ Camp George
⑮ Camp Carroll
⑯ Other _____

11. How much time on this tour have you spent in Area 1 for training or other reasons?

⓪ None
① 1 - 14 days
② 15 - 29 days
③ 1 - 3 months
④ 3 - 6 months
⑤ 6 - 12 months
⑥ More than 1 year

12. How much time on this tour have you spent in the demilitarized zone (DMZ) for training or other reasons?

⓪ None
① 1 - 14 days
② 15 - 29 days
③ 1 - 3 months
④ 3 - 6 months
⑤ 6 - 12 months
⑥ More than 1 year

13. Are you on a rotational unit assignment?

⓪ No
① Yes
② Unsure

14. Has your tour in the ROK been extended?

⓪ No
① Yes, voluntarily
② Yes, involuntarily

15. Do you have dependent family members?

⓪ No
① Yes, but not here
② Yes, here but not Command-sponsored
③ Yes, here and Command-sponsored

16. Since the beginning of this tour, how many times have you traveled outside of the ROK for leisure?

⓪ 0
① 1
② 2
③ 3 or more

17. Since the beginning of this tour, how many times have friends and/or family outside of the ROK come to visit you?

⓪ 0
① 1
② 2
③ 3 or more

18. On average during this tour, how many **HOURS** do you spend working per day?

0 ⓪ ⓪ 0
1 ① ① 1
2 ② ② 2
③ 3
④ 4
⑤ 5
⑥ 6
⑦ 7
⑧ 8
⑨ 9

19. On average during this tour, how many **DAYS** do you spend working per week?

⓪ 0
① 1
② 2
③ 3
④ 4
⑤ 5
⑥ 6
⑦ 7

20. On average, how many **DAYS** per week do you go off-post into the local community?

⓪ 0
① 1
② 2
③ 3
④ 4
⑤ 5
⑥ 6
⑦ 7

These questions ask you about previous tours you may have had in the ROK.

21. **Not including your current tour,** how many times have your been stationed in the ROK for **MORE THAN 30 DAYS?**

0 1 2 3 4 5 6 7

22. **Not including your current tour,** how many **TOTAL MONTHS** have you been stationed in the ROK?

0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7
8
9

23. Please indicate the month and year you returned from your last deployment **since 9/11/2001** (combat, peacekeeping, or humanitarian).

1 N/A, **skip to page 4, #29.**

Month: 1 Jan, 2 Feb, 3 Mar, 4 Apr, 5 May, 6 Jun, 7 Jul, 8 Aug, 9 Sep, 10 Oct, 11 Nov, 12 Dec

Year 200 0 0 0
1 1 1
2 2 2
3 3 3
4 4 4
5 5 5
6 6 6
7 7 7
8 8 8
9 9 9

24. How many **COMBAT** deployments **since 9/11/2001** have you completed that lasted more than 30 days (not training)?

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4
5
6
7
8
9

25. How many **TOTAL MONTHS** have you spent on a **COMBAT** deployment **since 9/11/2001?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

26. Before being stationed in the ROK, how many **peacekeeping or humanitarian** deployments **since 9/11/2001** have you completed that lasted more than 30 days?

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4
5
6
7
8
9

27. Before being stationed in the ROK, how many **TOTAL MONTHS** have you spent on a **peacekeeping or humanitarian** deployment **since 9/11/2001?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

28. Did you experience any of the following during **ANY OF YOUR COMBAT DEPLOYMENTS** since **9/11/2001?**

	Never	One Time	Two to Four Times	Five or More Times
Being attacked or ambushed	1	2	3	4
Shooting or directing fire at the enemy	1	2	3	4
Being wounded or injured	1	2	3	4
Improvised explosive device (IED)/booby trap exploded near you	1	2	3	4
Seeing dead bodies or human remains	1	2	3	4
Knowing someone seriously injured or killed	1	2	3	4
Witnessing violence within the local population or between ethnic groups	1	2	3	4
Providing aid to the wounded	1	2	3	4
Saving the life of a Soldier or civilian	1	2	3	4
Feeling directly responsible for the death of another person	1	2	3	4
Engaging the enemy in a firefight	1	2	3	4
Feeling in danger of being seriously wounded or killed	1	2	3	4
Handling or uncovering human remains	1	2	3	4

B. HEALTH AND WELL-BEING

Please consider the **PAST 4 WEEKS** when answering the following:

29. How often do you have a drink containing alcohol?

1. Never, **skip to page 5, #33**
2. Monthly or less
3. 2-4 times a month
4. 2-3 times a week
5. 4 or more times a week

30. How many drinks containing alcohol do you have on a **TYPICAL DAY** when you are drinking?

1. 1 or 2
2. 3 or 4
3. 5 or 6
4. 7, 8, or 9
5. 10 or more

31. How often do you have six or more drinks on one occasion?

1. Never
2. Less than Monthly
3. Monthly
4. Weekly
5. Daily or almost daily

32. Has your alcohol consumption increased since you've been stationed in the ROK?

0. No
1. Yes

33. During your current tour in the ROK, have you:	No	Yes
used alcohol to sleep?	0	1
used alcohol to deal with boredom?	0	1
used alcohol to forget about things?	0	1
used alcohol to calm down?	0	1
noticed your drinking affected your work performance?	0	1
used any illegal drugs/substances?	0	1
risked getting a sexually transmitted infection?	0	1
gambled away more money/possessions than you planned to?	0	1
participated in behaviors that could, if caught, result in UCMJ disciplinary actions?	0	1
had two or more energy drinks a day?	0	1
used prescription medication more than prescribed, or for other reasons (such as to get high)?	0	1
looked to start a fight?	0	1
demonstrated lack of discipline (was insubordinate, late to formation, poor military bearing, etc.)?	0	1
stayed out past curfew?	0	1
gotten into trouble with your leadership?	0	1
received a negative counseling statement?	0	1
had a family member or friend express concern about you?	0	1
had a supervisor express concern about your work performance?	0	1
experienced serious financial problems?	0	1
had a break-up of an important relationship?	0	1

34. Since the start of your tour, have you ever, even once, used any prescription pain reliever in any way a doctor did not direct you to use it?

0 No
1 Yes
2 Unsure

35. Please indicate how much you **AGREE** or **DISAGREE** with the following:

	No	Yes
I would know where to go if I had a problem with alcohol or another substance (illicit or prescription).	0	1
If I recognized that I had a problem with alcohol or another substance (illicit or prescription), I would seek help.	0	1
If someone told me I had a problem with alcohol or another substance (illicit or prescription), I would seek help.	0	1
If I recognized that another Soldier had a problem with alcohol or another substance (illicit or prescription), I would encourage them to get help.	0	1
There are fewer negative consequences when Soldiers seek out help for alcohol or substance abuse (illicit or prescription) problems than when their Command directs them to get help.	0	1

36. Below is a list of reactions that Soldiers sometimes experience in response to stressful life experiences. Please mark how much you have been bothered by each problem **IN THE PAST MONTH.**	NOT AT ALL	A LITTLE BIT	MODER-ATELY	QUITE A BIT	EX-TREMELY
Repeated, disturbing, and unwanted memories of the stressful experience	1	2	3	4	5
Repeated, disturbing *dreams* of the stressful experience	1	2	3	4	5
Suddenly feeling or acting as if the stressful experience *were actually happening again* (as if you were back there re-living it)	1	2	3	4	5
Feeling very upset when *something reminded* you of the stressful experience	1	2	3	4	5
Having strong *physical reactions* when something reminded you of the stressful experience (like heart pounding, trouble breathing, sweating)	1	2	3	4	5
Avoiding memories, thoughts, or feelings related to the stressful experience	1	2	3	4	5
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)	1	2	3	4	5
Trouble remembering important parts of the stressful experience	1	2	3	4	5
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)	1	2	3	4	5
Blaming yourself or someone else for the stressful experience or what happened after it	1	2	3	4	5
Having strong negative feelings such as fear, horror, anger, guilt, or shame	1	2	3	4	5
Loss of interest in activities that you used to enjoy	1	2	3	4	5
Feeling *distant or cut-off* from other people	1	2	3	4	5
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)	1	2	3	4	5
Irritable behavior, angry outbursts, or acting aggressively	1	2	3	4	5
Taking too many risks or doing things that could cause you harm	1	2	3	4	5
Being *"super alert"* or watchful or on-guard	1	2	3	4	5
Feeling *jumpy* or easily startled	1	2	3	4	5
Having *difficulty concentrating*	1	2	3	4	5
Trouble *falling or staying asleep*	1	2	3	4	5
Feeling as if your *future* somehow will be *cut short*	1	2	3	4	5

37. Since being stationed in the ROK:	No	Yes	Unsure
Have you suffered forced sexual relations or sexual assault?	0	1	2
Have you experienced sexual harrassment?	0	1	2

38. Since being stationed in the ROK: I have noticed sexual harassment occurring to others.

⓪ No, **skip to #40**
① Yes, **continue to #39**
② Unsure, **continue to #39**

39. If Yes to #38, in response to this situation, select the one response that most closely resembles your actions.

① I have not observed any sexual harassment
② I decided not to take action
③ I stepped in and separated the people involved in the situation
④ I asked the person who appeared to be the target of the harassment if they needed help
⑤ I confronted the person who appeared to be causing the situation
⑥ I created a distraction to cause one or more of the people to disengage from the situation
⑦ I asked others to step in as a group and reduce the tension
⑧ I told someone in a position of authority about the situation

40. In a typical week, I do **VIGOROUS** physical activities: (**VIGOROUS** activities cause **HEAVY** sweating or **LARGE** increases in breathing and heart rate)

Day(s) per week: ① ② ③ ④ ⑤ ⑥ ⑦

Minutes per day on the day(s) you work out: _____

41. In a typical week, I do **LIGHT OR MODERATE** physical activities: **LIGHT OR MODERATE** activities cause **ONLY LIGHT** sweating or a **SLIGHT** to **MODERATE** increases in breathing and heart rate)

Day(s) per week: ① ② ③ ④ ⑤ ⑥ ⑦

Minutes per day on the day(s) you work out: _____

42. In a typical week, I do physical activities specifically designed to **STRENGTHEN** my muscles such as lifting weights or doing calisthenics

Day(s) per week: ① ② ③ ④ ⑤ ⑥ ⑦

43. Think about the **PAST 30 DAYS.** How often did you eat/drink the following foods/beverages?

	1 or 2 Servings per Week	3 to 6 Servings per Week	1 Serving per Day	2 to 3 Servings per Day	4 or More Servings per Day
Fruits	①	②	③	④	⑤
Vegetables	①	②	③	④	⑤
Whole Grains	①	②	③	④	⑤
Dairy	①	②	③	④	⑤
Fish	①	②	③	④	⑤
Lean Protein	①	②	③	④	⑤
Sugar-Sweetened Beverages	①	②	③	④	⑤

44. Over the **PAST MONTH**, how often have you been bothered by any of the following problems?	Not At All	Few or Several Days	More Than Half The Days	Nearly Every Day
Little interest or pleasure in doing things.	1	2	3	4
Feeling down, depressed, or hopeless.	1	2	3	4
Trouble falling or staying asleep, or sleeping too much.	1	2	3	4
Feeling tired or having little energy.	1	2	3	4
Poor appetite or overeating.	1	2	3	4
Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	1	2	3	4
Trouble concentrating on things, such as reading the newspaper or watching television.	1	2	3	4
Moving or speaking so slowly that other people could have noticed.	1	2	3	4
Thoughts that you would be better off dead or of hurting yourself in some way.	1	2	3	4
Feeling nervous, anxious, on edge.	1	2	3	4
Not being able to stop or control worrying.	1	2	3	4
Worrying too much about different things.	1	2	3	4
Trouble relaxing.	1	2	3	4
Feeling restless so that it's hard to sit still.	1	2	3	4
Becoming easily annoyed or irritable.	1	2	3	4
Feeling afraid as if something awful might happen.	1	2	3	4

45. If you checked off **ANY** of the above problems (question 44), how **DIFFICULT** have these problems made it for you to do your work, or get along with other people?

1. Not difficult at all
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

46. Please respond to the following:	Definitely True	Probably True	Probably False	Definitely False
If I wanted to go on a trip for a day (for example, to the country or mountains), I would have a hard time finding someone to go with me.	1	2	3	4
If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.	1	2	3	4
I don't often get invited to do things with others.	1	2	3	4
If I wanted to have lunch with someone, I could easily find someone to join me.	1	2	3	4

47. The next questions are about how you feel about different aspects of your life. For each one, indicate how often you feel that way.	Hardly Ever	Some of the Time	Often
How often do you feel that you lack companionship?	1	2	3
How often do you feel left out?	1	2	3
How often do you feel isolated from others?	1	2	3

48. Think about your experiences on this tour. Rate how much **TROUBLE** or **CONCERN** has been caused by:

	NONE	VERY LOW	LOW	MEDIUM	HIGH	VERY HIGH
Being separated from family	①	②	③	④	⑤	⑥
Illness or problems back home	①	②	③	④	⑤	⑥
Boring and repetitive work	①	②	③	④	⑤	⑥
Difficulties communicating back home (e.g. phone calls, email, mail)	①	②	③	④	⑤	⑥
Uncertain tour length	①	②	③	④	⑤	⑥
Long tour length	①	②	③	④	⑤	⑥
Lack of privacy or personal space	①	②	③	④	⑤	⑥
Lack of time off for personal time	①	②	③	④	⑤	⑥
Not having the right equipment or repair parts	①	②	③	④	⑤	⑥
Not getting enough sleep	①	②	③	④	⑤	⑥
Working with KATUSA	①	②	③	④	⑤	⑥
Threat from North Korea	①	②	③	④	⑤	⑥
Crossing the border by accident	①	②	③	④	⑤	⑥
Causing an international incident by accident	①	②	③	④	⑤	⑥
Stress related to major exercise (such as Key Resolve and UFG)	①	②	③	④	⑤	⑥

49. How often in the **PAST MONTH** did you....

	Never	One Time	Two Times	Three or Four Times	Five or More Times
Get angry at someone and yell or shout at them.	①	②	③	④	⑤
Get angry with someone and kick or smash something, slam the door, punch the wall, etc.	①	②	③	④	⑤
Threaten someone with physical violence.	①	②	③	④	⑤
Get into a fight with someone and hit the person.	①	②	③	④	⑤

50. Does anger help you in any way to perform your duties (such as helps you focus, motivate you)?

① Not At All
② Rarely
③ Sometimes
④ Often
⑤ Very Often

51. The following questions ask you to think about yourself and other people. Please respond to each question by using your own current beliefs and experiences, **NOT** what you think is true in general, or what might be true for other people. Please base your responses on how you've been feeling recently. Use the rating scale to find the number that best matches how you feel and fill in that number. There are no right or wrong answers: we are interested in what you *think* and feel.

	Not at all true for me			Some-what true for me			Very true for me
These days, the people in my life would be better off if I were gone	①	②	③	④	⑤	⑥	⑦
These days, the people in my life would be happier without me	①	②	③	④	⑤	⑥	⑦
These days, I think I am a burden on society	①	②	③	④	⑤	⑥	⑦
These days, I think my death would be a relief to the people in my life	①	②	③	④	⑤	⑥	⑦
These days, I think the people in my life wish they could be rid of me	①	②	③	④	⑤	⑥	⑦
These days, I think I make things worse for the people in my life	①	②	③	④	⑤	⑥	⑦
These days, other people care about me	①	②	③	④	⑤	⑥	⑦
These days, I feel like I belong	①	②	③	④	⑤	⑥	⑦
These days, I rarely interact with people who care about me	①	②	③	④	⑤	⑥	⑦
These days, I am fortunate to have many caring and supportive friends	①	②	③	④	⑤	⑥	⑦
These days, I feel disconnected from other people	①	②	③	④	⑤	⑥	⑦
These days, I often feel like an outsider in social gatherings	①	②	③	④	⑤	⑥	⑦
These days, I feel that there are people I can turn to in times of need	①	②	③	④	⑤	⑥	⑦
These days, I am close to other people	①	②	③	④	⑤	⑥	⑦
These days, I have at least one satisfying interaction every day	①	②	③	④	⑤	⑥	⑦

52. During the **PAST YEAR,** did you:	NO	YES
Often think a lot about death, either your own or someone else's or death in general?	⓪	①
Seriously think about committing suicide?	⓪	①
Make a plan for committing suicide?	⓪	①
In your LIFETIME, have you ever attempted suicide?	⓪	①
Know someone who attempted or completed suicide?	⓪	①

C. WORK ENVIRONMENT

53. Please indicate how much you disagree or agree with the following statements:	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I have so much work to do, I cannot do everything well.	①	②	③	④	⑤
I never seem to have enough time to get everything done.	①	②	③	④	⑤
My job leaves me with little time to get things done.	①	②	③	④	⑤

54. Rate the following:

	VERY LOW	LOW	MEDIUM	HIGH	VERY HIGH
Your personal morale	1	2	3	4	5
Morale in your unit	1	2	3	4	5

55. My Platoon Sergeant (or equivalent) has deployed to Iraq or Afghanistan.

0 No
1 Yes
2 Unsure
3 Does not apply

56. My Platoon Sergeant (or equivalent) has experience with Korean culture.

0 No
1 Yes
2 Unsure
3 Does not apply

57. For the folllowing statements, complete the answer that best describes your opinion of what is generally true regarding your leaders.

My Platoon Sergeant (or equivalent)...	Never	Seldom	Some-times	Often	Always
tells Soldiers when they have done a good job.	1	2	3	4	5
embarrasses Soldiers in front of other Soldiers.	1	2	3	4	5
tries to look good to higher-ups by assigning extra missions or details to Soldiers.	1	2	3	4	5
exhibits clear thinking and reasonable action under stress.	1	2	3	4	5
My Platoon Leader (or equivalent)...					
tells Soldiers when they have done a good job.	1	2	3	4	5
embarrasses Soldiers in front of other Soldiers.	1	2	3	4	5
tries to look good to higher-ups by assigning extra missions or details to Soldiers.	1	2	3	4	5
exhibits clear thinking and reasonable action under stress.	1	2	3	4	5

58. For the following statements, complete the answer that best describes your opinion of what is generally true using the scale provided.

My Platoon Leader (or equivalent)...	Never	Seldom	Some-times	Often	Always
Asks Soldiers about their sleeping habits.	1	2	3	4	5
Encourages Soldiers to get adequate sleep.	1	2	3	4	5
Considers sleep as an important planning factor.	1	2	3	4	5
Encourages Soldiers to nap when possible.	1	2	3	4	5
Encourages Soldiers to get extra sleep before missions that require long hours.	1	2	3	4	5
Works to ensure Soldiers have a good sleep environment (quiet, dark, not too hot or cold).	1	2	3	4	5
Supports the appropriate use of prescription sleep medications (like Ambien) when Soldiers need help with sleeping.	1	2	3	4	5
Discourages the use of caffeine or nicotine use within several hours before trying to go to sleep.	1	2	3	4	5
Encourages Soldiers to try to go to sleep on time.	1	2	3	4	5

59. For the following statements, complete the answer that best describes your opinion of what is generally true using the scale provided.

My Platoon Sergeant (or equivalent)...	Never	Seldom	Some-times	Often	Always
intervenes when a Soldier displays stress reactions such as anxiety, depression or other behavioral health problems.	1	2	3	4	5
demonstrates concern for how families are dealing with stress.	1	2	3	4	5
encourages Soldiers who seek behavioral health help.	1	2	3	4	5
does not judge Soldiers who seek behavioral health help.	1	2	3	4	5
encourages Soldiers to express emotions following losses and setbacks during deployment.	1	2	3	4	5
reminds Soldiers after intense experiences that we are here to serve with honor, serve a mission, and serve a greater purpose.	1	2	3	4	5

60. Tell us how much you **DISAGREE** or **AGREE** with the statements below about your military job.

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
The members of my platoon are cooperative with each other.	1	2	3	4	5
The members of my platoon know that they can depend on each other.	1	2	3	4	5
The members of my platoon stand up for each other.	1	2	3	4	5
I think my platoon would do an excellent job in combat.	1	2	3	4	5
I think the level of training in my platoon is high.	1	2	3	4	5
I have real confidence in my platoon's ability to perform its mission.	1	2	3	4	5
The members of my platoon would risk their lives for each other.	1	2	3	4	5

61. Please indicate how much you **DISAGREE** or **AGREE** with the following:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I am confident in my ability to identify Soldiers at risk for suicide.	1	2	3	4	5
I am confident in my ability to help Soldiers get mental health assistance.	1	2	3	4	5

D. HEALTH AND WELLNESS

62. Think about your experience on **THIS TOUR** so far in terms of your primary location. Please rate the quality of the following:

	NOT AVAIL-ABLE	LOW	MEDIUM	HIGH	DOES NOT APPLY
Food	1	2	3	4	5
Living conditions	1	2	3	4	5
Religious services	1	2	3	4	5
Opportunities for continuing education	1	2	3	4	5
AAFES (PX, Shoppette)	1	2	3	4	5
Child, Youth and School Services (CYS)	1	2	3	4	5
Child Development Center (CDC)	1	2	3	4	5
Medical Services	1	2	3	4	5
Schools	1	2	3	4	5
MWR	1	2	3	4	5
Commissary	1	2	3	4	5
Army Community Services (ACS)	1	2	3	4	5

63. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I deal with stress better because of this tour.	1	2	3	4	5
This tour allows me to strengthen my military skills.	1	2	3	4	5
I like the chance to help preserve the peace in this region.	1	2	3	4	5
I like the chance to continue my education during this tour.	1	2	3	4	5
This tour is career enhancing for me.	1	2	3	4	5
I am making a direct contribution to this mission.	1	2	3	4	5
This tour is an adventure.	1	2	3	4	5
I like interacting with KATUSA.	1	2	3	4	5
I like interacting with ROK military members.	1	2	3	4	5

64. On average, how many hours of sleep do you get per day?

1. 3 or fewer
2. 4
3. 5
4. 6
5. 7
6. 8 or more

65. Please rate your sleep pattern for the past 2 weeks.

	NONE	MILD	MODER-ATE	SEVERE	VERY SEVERE
Difficulty falling asleep	1	2	3	4	5
Difficulty staying asleep	1	2	3	4	5
Problems waking up too early	1	2	3	4	5

66. How **SATISFIED/DISSATISFIED** are you with your current sleep pattern?

1. Very satisfied
2. Satisfied
3. Moderately satisfied
4. Dissatisfied
5. Very dissatisfied

67. How **NOTICEABLE** to others do you think your sleep pattern is in terms of impairing the quality of your life?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

68. How **WORRIED/DISTRESSED** are you about your current sleep pattern?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

69. To what extent do you consider your sleep pattern to **INTERFERE** with your daily functioning (such as daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, etc.)?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

70. Overall, in the **PAST MONTH**, how would you rate your health?

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

71. How often in the **PAST MONTH** have you gone to sick call or visited a doctor or other medical professional for a physical condition?

1. Zero times
2. One time
3. Two times
4. Three or Four Times
5. Five or More Times

72. During this tour, have you had an accident or made a mistake that affected the mission?
(0) No
(1) Yes

E. HEALTH CARE - The following section asks questions about health care for a stress, emotional, alcohol and/or family related problem.

73. During this tour, have you experienced a stress, emotional, alcohol, or family problem?
(0) No
(1) Yes, Mild
(2) Yes, Moderate
(3) Yes, Severe

74. Are you **CURRENTLY** interested in receiving help for a stress, emotional, alcohol or family problem?
(0) No
(1) Yes

75. In the **PAST YEAR,** did you receive behavioral health services for a stress, emotional, alcohol, or family problem from a:

	No	Yes
Behavioral health professional?	(0)	(1)
General medical doctor?	(0)	(1)
Military chaplain?	(0)	(1)
Military and Family Life Consultant (MFLC)?	(0)	(1)
Military OneSource?	(0)	(1)
Medic/corpsman in your unit?	(0)	(1)
Another member of your unit (not including the medic/corpsman)?	(0)	(1)
FAP?	(0)	(1)
ASAP?	(0)	(1)
Other _____	(0)	(1)

TELEBEHAVIORAL HEALTH - Telebehavioral Health uses video chat technologies to conduct behavioral health services in the ROK.

76. Is Telebehavioral health available in your location?
(0) No
(1) Yes
(2) Don't know

77. Have you ever used telebehavioral health?
(0) No, **skip to #79**
(1) Yes, **continue to next question**

78. Please indicate how much your **DISAGREE** or **AGREE** with the following:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I felt there was enough privacy during my telebehavioral health appointment.	(1)	(2)	(3)	(4)	(5)
I would be willing to see a behavioral health provider again using telebehavioral health.	(1)	(2)	(3)	(4)	(5)
I felt comfortable discussing my issues with a behavioral health provider using telebehavioral health.	(1)	(2)	(3)	(4)	(5)

79. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem during this deployment:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
It's too difficult to get to the location where the mental health specialist is.	1	2	3	4	5
My leaders discourage the use of mental health services.	1	2	3	4	5
I might be given medicine that would interfere with my ability to do my job.	1	2	3	4	5
Mental health professionals do not come to my location often enough.	1	2	3	4	5
The military supports Soldiers who have mental health problems.	1	2	3	4	5
My unit leadership might treat me differently.	1	2	3	4	5
Members of my unit might have less confidence in me.	1	2	3	4	5
I would be seen as weak.	1	2	3	4	5
My leaders would blame me for the problem.	1	2	3	4	5
It would harm my career.	1	2	3	4	5
It might affect my security clearance.	1	2	3	4	5
It would be too embarrassing.	1	2	3	4	5
It is difficult to get an appointment.	1	2	3	4	5
Mental health services aren't available.	1	2	3	4	5
I don't know where to get help.	1	2	3	4	5
My workload does not allow time for treatment.	1	2	3	4	5
There would be difficulty getting time off work for treatment.	1	2	3	4	5
I don't trust mental health professionals.	1	2	3	4	5
My supervisor tells me I should get checked out.	1	2	3	4	5
I prefer to manage my problems on my own.	1	2	3	4	5
Mental health care doesn't work.	1	2	3	4	5

80. What is your **current marital status?**

1. Single, never married - Continue to # 81.
2. Married - Skip to #82.
3. Separated - Skip to #82.
4. Divorced - Continue to #81.
5. Widowed - Continue to #81.

81. Are you currently in a committed relationship (e.g., fiance, girlfriend/boyfriend)?

0. No, **SURVEY COMPLETE**
1. Yes, Skip to #83.

82. How many years have you been married to your **CURRENT SPOUSE?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6
7 7
8 8
9 9

83. Are you or your spouse/partner currently planning to end the relationship (break-up, divorce or separation)?

0. No
1. Yes
2. Unsure

84. Is your spouse or significant other Korean?

0. No
1. Yes

85. In the last year, infidelity (cheating) has been a problem in my relationship.

⓪ No
① Yes
② Unsure

86. On a scale of 1 to 10, rate your overall satisfaction with your marriage or committed relationship, with 1 being **VERY UNSATISFIED** and 10 being **EXTREMELY SATSIFIED.**

Very Unsatisfied ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Extremely Satisfied

87. Please rate how much you disagree or agree with the following:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I have a good marriage/relationship.	①	②	③	④	⑤
My relationship with my spouse/significant other is very stable.	①	②	③	④	⑤
My relationship with my spouse/significant other makes me happy.	①	②	③	④	⑤
I really feel like a part of a team with my spouse/significant other.	①	②	③	④	⑤

THANK YOU FOR COMPLETING THIS SURVEY
PLEASE PROVIDE ANY ADDITIONAL COMMENTS BELOW.

14 APPENDIX B: BEHAVIORAL HEALTH STAFF SURVEY

(begins on next page)

Republic of Korea (ROK)
Behavioral Health (BH) Staff Survey

DATE		
MONTH	DAY	YEAR
1 JAN		
2 FEB		
3 MAR	0 0	0 0 0 0
4 APR	1 1	1 1 1 1
5 MAY	2 2	2 2 2 2
6 JUN	3 3	3 3 3
7 JUL	4	4 4 4
8 AUG	5	5 5 5
9 SEP	6	6 6 6
10 OCT	7	7 7 7
11 NOV	8	8 8 8
12 DEC	9	9 9 9

I RECEIVED AN INFORMATION SHEET AND I AGREE TO ALLOW MY SURVEY RESPONSES TO BE USED FOR RESEARCH PURPOSES
0 No
1 Yes

WRAIR #2291
v2 21DEC15

A. Demographics

1. GENDER
   1 Male
   2 Female

2. GRADE/RANK
   1 E1 - E3
   2 E4
   3 E5 - E9
   4 Officer/Warrant Officer
   5 NA-Civilian

3. Please best describe yourself:
   1 Uniformed Services
   2 DA Civilian
   3 Contractor
   4 Other _____

4. What best describes your duty this tour?
   1 Primarily patient care - no staff work
   2 Primarily patient care - some staff work
   3 Primarily staff work - no patient care
   4 Primarily staff work - some patient care

5. How much time on this tour have you spent in Area 1 for training or other reasons?
   0 None
   1 1 - 14 days
   2 15 - 29 days
   3 1 - 3 months
   4 3 - 6 months
   5 6 - 12 months
   6 More than 1 year

6. Where do you do most of your work?
   1 Hospital
   2 Outlying clinic
   3 Other _____

7. For **THIS** tour, please indicate **MONTH/YEAR** you arrived in the ROK:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1	2	3	4	5	6	7	8	9	10	11	12

Year	Prior to 2014	2014	2015	2016
	1	2	3	4

8. For **THIS** tour, please indicate **MONTH/YEAR** you **EXPECT TO LEAVE** the ROK:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	1	2	3	4	5	6	7	8	9	10	11	12

Year	2016	2017	2018
	1	2	3

9. I am currently providing backfill clinical support.
   0 No
   1 Yes

10. How many years have you been working in a military health care setting?
    0 0 0 0
    1 1 1 1
    2 2 2 2
    3 3 3 3
    4 4
    5 5
    6 6
    7 7
    8 8
    9 9

[Serial #]

11. How many times since September 11, 2001 did you deploy for more than 30 days to any of the following **INCLUDING THIS DEPLOYMENT? MARK ALL THAT APPLY**

	Never	One Time	Two Times	Three Times	Four or More Times
Iraq (OIF/OND)	1	2	3	4	5
Afghanistan (OEF)	1	2	3	4	5
Other _____	1	2	3	4	5

12. How many **COMBAT** deployments **since 9/11/2001** have you completed that lasted **MORE THAN 30 DAYS** (not including training exercises)?

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4
5 5
6 6
7 7
8 8
9 9

13. How many **TOTAL MONTHS** have you spent on a **COMBAT** deployment **since 9/11/2001?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

14. Before being stationed in the ROK, how many **peacekeeping or humanitarian** deployments **since 9/11/2001** have you completed that lasted **MORE THAN 30 DAYS?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4
5 5
6 6
7 7
8 8
9 9

15. Before being stationed in the ROK, how many **TOTAL MONTHS** have you spent on a **peacekeeping or humanitarian** deployment **since 9/11/2001?**

0 0 0 0
1 1 1 1
2 2 2 2
3 3 3 3
4 4 4 4
5 5 5 5
6 6 6 6
7 7 7 7
8 8 8 8
9 9 9 9

B. Standards and Coordination

16. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
The standards of BH care in the ROK are clear.	1	2	3	4	5
The standards of BH services in the ROK are clear.	1	2	3	4	5
The standards for clinical documentation in the ROK are clear.	1	2	3	4	5
The standards for records management in the ROK are clear.	1	2	3	4	5
Commanders are satisfied with the amount of information I can provide.	1	2	3	4	5
The standards of how much patient information I can share with commanders are clear.	1	2	3	4	5

17. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
My higher headquarters provides us with the resources required to conduct our BH mission.	1	2	3	4	5
My higher headquarters encourages us to provide feedback/comments regarding ROK BH policies.	1	2	3	4	5
We coordinate/integrate our BH activities with the Chaplains/Chaplains' Assistants in the ROK.	1	2	3	4	5
We coordinate/integrate our BH activities with primary care.	1	2	3	4	5

C. Behavioral Health Services

18. During this tour, how frequently have you:	NEVER	ONLY ONCE	ONCE EVERY 2-3 MONTHS	ONCE A MONTH	TWO TO THREE TIMES A MONTH	ONCE A WEEK	SEVERAL TIMES A WEEK
Conducted educational classes?	1	2	3	4	5	6	7
Consulted with unit leaders?	1	2	3	4	5	6	7
Conducted psychological debriefings?	1	2	3	4	5	6	7
Conducted Unit Behavioral Health Needs Assessments (UBHNA)?	1	2	3	4	5	6	7
Conducted other systematic unit needs assessments?	1	2	3	4	5	6	7
Conducted Suicide Prevention Training?	1	2	3	4	5	6	7
Provided one-to-one BH counseling with Service Members at their worksite?	1	2	3	4	5	6	7
Provided one-to-one BH counseling with Service Members in a BH setting?	1	2	3	4	5	6	7

19. Has your program required backfill to meet its clinical needs?
- 0 No, Skip to #23
- 1 Yes, continue to #20
- 2 Unsure

20. If Yes to #19, please identify the program that required backfill. **MARK ALL THAT APPLY.**
- 1 AMIOP
- 2 CAFBHS
- 3 FAP
- 4 EBH
- 5 EDIS
- 6 IBH (inpatient)
- 7 Multi-D
- 8 ASAP
- 9 Unsure

21. If Yes to #19, how long was backfill required?
- 1 Less than 1 month
- 2 1-3 months
- 3 4-6 months
- 4 More than 6 months

22. If Yes to #19, indicate if backfill has been helpful.
- 1 Strongly disagree
- 2 Disagree
- 3 Neither agree nor disagree
- 4 Agree
- 5 Strongly agree

23. On average, how many days do patients wait for a first appointment?

Example: If 20, then bubble "020"

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

24. The frequency of staff/provider turnover negatively impacts clinic operations.
- 1 Strongly disagree
- 2 Disagree
- 3 Neither agree nor disagree
- 4 Agree
- 5 Strongly agree

D. TELEBEHAVIORAL HEALTH - Telebehavioral Health (TBH) uses video chat technologies to conduct behavioral health consultations in the ROK.

25. Is telebehavioral health available in your location?
    (0) No
    (1) Yes
    (2) Don't know

26. Is telebehavioral health available in locations you support (other than your primary location)?
    (0) No
    (1) Yes
    (2) Don't know
    (3) Don't support other locations

27. Is bandwidth sufficient to support telebehavioral health in your location.
    (0) No
    (1) Yes
    (2) Don't know

28. Is bandwidth sufficient to support telebehavioral health in locations you support (other than your primary location)?
    (0) No
    (1) Yes
    (2) Don't know
    (3) Don't support other locations

29. Have you ever provided care using telebehavioral health?
    (0) No, please skip to #33
    (1) Yes, continue to #30

30. Please indicate how much you agree or disagree with the following:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I felt there was enough privacy during my telebehavioral health encounter.	(1)	(2)	(3)	(4)	(5)
Using telebehavioral health technology is an efficient method for delivering health care.	(1)	(2)	(3)	(4)	(5)
I felt comfortable discussing Service Members' issues over telebehavioral health technology.	(1)	(2)	(3)	(4)	(5)

31. In the ROK, I prefer providing counseling/BH services:
    (1) Face-to-Face
    (2) Using telebehavioral health
    (3) Mix of face-to-face and telebehavioral health
    (4) No preference

32. What is the primary format under which you provide care?
    (1) Telebehavioral health
    (2) In-person
    (3) Combination of telebehavioral health and in-person

33. Do you have access to the Behavioral Health Data Portal (BHDP) for your patients?
    (0) No, please skip to page 5, #36
    (1) Yes
    (2) Don't know

34. If Yes to #33, how often do you review your patients' BHDP data?
    (1) Never
    (2) Intake only
    (3) Periodically
    (4) Every encounter

35. If Yes to #33, how often do you discuss your patients' BHDP data with them?
    (1) Never
    (2) Intake only
    (3) Periodically
    (4) Every encounter

36. Thinking about your current team, rate how often your **LEADERS:**

	Never	Seldom	Frequently	Always
Emphasize maintaining compassion.	1	2	3	4
Emphasize maintaining professional standards.	1	2	3	4
Emphasize taking care of yourself mentally.	1	2	3	4
Emphasize taking care of yourself physically.	1	2	3	4
Remind you to take a break/recharge.	1	2	3	4
Encourage you to get enough sleep.	1	2	3	4
Give you specific guidance on how to improve.	1	2	3	4
Reduce tension in the team when emotions run high.	1	2	3	4
Give you positive feedback about your accomplishments.	1	2	3	4
Emphasize the importance of the medical mission.	1	2	3	4

E. Skills, Training and Work Environment

37. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:

I feel confident in my ability to:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
Help Service Members adapt to the stressors of being stationed in the ROK.	1	2	3	4	5
Evaluate and manage Service Members with suicidal thoughts/behaviors.	1	2	3	4	5
Evaluate and treat Service Members with substance abuse/dependence.	1	2	3	4	5
Evaluate and treat Acute Stress Disorder/PTSD.	1	2	3	4	5
Evaluate and treat victims of sexual assault.	1	2	3	4	5

38. Is more training/education needed for yourself or your unit in the following areas:

	No	Yes
Evidenced-based treatment	0	1
Managing suicidal behavior	0	1
Provider resilience	0	1
Return to duty decisions	0	1
Managing traumatic events	0	1
Alcohol and substance abuse assessment	0	1
Alcohol and substance abuse treatment	0	1
Managing marital or family problems	0	1

39. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I have so much work to do, I cannot do everything well.	1	2	3	4	5
I never seem to have enough time to get everything done.	1	2	3	4	5
My job leaves me with little time to get things done.	1	2	3	4	5

40. On this tour, have you ever placed Service Members on a duty limitation for psychological reasons?
(0) No, skip to #41.
(1) Yes, continue to #40a.

40a. How often do you have to make these decisions?	40b. How confident are you about these decisions?	40c. How difficult are these decisions?	40d. How trained are you in making hese decisions?
(1) Not At All (2) Rarely (3) Sometimes (4) Frequently (5) Very Frequently	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very

41. On this tour, have you ever made return to duty decisions for psychological reasons?
(0) No, skip to #42.
(1) Yes, continue to #41a.

41a. How often do you have to make these decisions?	41b. How confident are you about these decisions?	41c. How difficult are these decisions?	41d. How trained are you in making these decisions?
(1) Not At All (2) Rarely (3) Sometimes (4) Frequently (5) Very Frequently	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very	(1) Not at all (2) A little bit (3) Somewhat (4) Moderately (5) Very

42. When you work with people as a professional in the medical system you have direct contact with their lives. As you may have found, your compassion for those you work with can affect you in positive and negative ways. Below are some questions about you and your current work situation. Rate how often you experienced these things in the last 30 days.

	Never	Rarely	Sometimes	Often	Very Often
I get satisfaction from being able to help people.	(1)	(2)	(3)	(4)	(5)
I feel invigorated after working with those I help.	(1)	(2)	(3)	(4)	(5)
My work makes me feel satisfied.	(1)	(2)	(3)	(4)	(5)
I have happy thoughts and feelings about those I help and how I could help them.	(1)	(2)	(3)	(4)	(5)
I am proud of what I can do to help.	(1)	(2)	(3)	(4)	(5)
I have thoughts that I am a "success" as a helper.	(1)	(2)	(3)	(4)	(5)
I am happy that I chose to do this work.	(1)	(2)	(3)	(4)	(5)

43. Please rate the following:	Every Day	A Few Times A Week	Once A Week	A Few Times A Month	Once A Month or Less	A Few Times A Year	Never
I feel I treat some patients as if they were impersonal objects.	1	2	3	4	5	6	7
I've become more calloused towards people since I took this job	1	2	3	4	5	6	7
I don't really care what happens to some patients.	1	2	3	4	5	6	7
I feel emotionally drained from my work.	1	2	3	4	5	6	7
I feel fatigued when I get up in the morning.	1	2	3	4	5	6	7
Working with people all day is a real strain for me.	1	2	3	4	5	6	7
I deal very effectively with the problems of my patients.	1	2	3	4	5	6	7
I am positively influencing other people's lives through my work.	1	2	3	4	5	6	7
I feel exhilarated after working closely with my patients.	1	2	3	4	5	6	7
I think of giving up healthcare for another career.	1	2	3	4	5	6	7
I reflect on the satisfaction I get from being a healthcare professional.	1	2	3	4	5	6	7
I regret my decision to have become a healthcare professional.	1	2	3	4	5	6	7

44. How often do you do the following in providing buddy/peer support to the health care staff you work with?	Never	Rarely	Sometimes	Fairly Often	Often
Share stories	1	2	3	4	5
Look out for buddies in trouble	1	2	3	4	5
Normalize reactions	1	2	3	4	5
Joke around/use humor	1	2	3	4	5
Socialize/do fun things	1	2	3	4	5
Engage someone in conversation to find out how they are doing	1	2	3	4	5
Decompress together	1	2	3	4	5
Talk about non-work related topics	1	2	3	4	5
Exercise together	1	2	3	4	5
Other (Specify) _____	1	2	3	4	5

45. How often do you do the following:	Never	Rarely	Sometimes	Fairly Often	Often
Make time for self-reflection.	1	2	3	4	5
Ask for help when I need it.	1	2	3	4	5
Take time to chat with peers or those with whom I work.	1	2	3	4	5
Take time to meditate, pray or connect spiritually.	1	2	3	4	5
Seek out comforting things (such as activities, objects, people, or places).	1	2	3	4	5
Challenge myself to try something new.	1	2	3	4	5
Am physically active.	1	2	3	4	5
Get enough sleep.	1	2	3	4	5
Say no to extra responsibilities.	1	2	3	4	5
Acknowledge when I have accomplished a goal successfully.	1	2	3	4	5

46. In your **LAST <u>TYPICAL</u> WORK WEEK**, how many **HOURS** did you spend in each of the following activities, as part of your DoD duties? Note: May add up to more than 40 hours. **MARK ZERO IF YOU DID NOT DO THE ACTIVITY DURING YOUR LAST TYPICAL WORK WEEK.**

Direct patient care (i.e., only time spent in direct patient contact, including patient contact for command-directed evaluations, security clearances, and mental status exams, etc.)	_____
Administrative activities directly related to patient care (include time spent on medical charts/notes and medical evaluation boards not during the patient's visit)	_____
Administrative activities not directly related to patient care (e.g., staff committees, ENHSR, administration of a facility or organization)	_____
Command consultation (e.g., time spent with units related to BH issues)	_____
Mandatory training (e.g., HIPAA, EO, military, etc)	_____
Medical research	_____
Supervision of residents/other trainees	_____
Forensics	_____
Other professional activities (e.g., teaching, clinical consultations), Please specify: _____	_____

47. The following questions ask about your feelings regarding evidence-based treatment. Evidence-based treatments are identified by a consensus committee of experts. These experts have examined the peer reviewed literature and rated the level of evidence for that treatment; the ratings are usually summarized in Clinical Practice Guides.

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
I am willing to use new and different types of treatments if they have evidence of being effective.	①	②	③	④	⑤
Evidence-based treatments do not allow me to tailor my therapy to each client's needs.	①	②	③	④	⑤
Clinical experience and judgment are more important than using evidence-based treatments.	①	②	③	④	⑤
I like using evidence-based treatments because of the structure they provide.	①	②	③	④	⑤
A problem with evidence-based treatments is that you need to learn a different program for each diagnosis or problem area.	①	②	③	④	⑤
Evidence-based treatments allow clinicians to respond to important events in therapy as they come up.	①	②	③	④	⑤
I dislike evidence-based treatments because they are too inflexible.	①	②	③	④	⑤
Evidence-based treatments are not designed to handle patients with more than one diagnosis or other challenges that are common in real world therapy.	①	②	③	④	⑤

48. Please indicate how much you **DISAGREE** or **AGREE** with the following statements:

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
The medical leadership doesn't support BH outreach.	1	2	3	4	5
Units' leadership doesn't support BH activities.	1	2	3	4	5
I don't have adequate time to conduct outreach activities.	1	2	3	4	5
Commanders support BH provider recommendations for reassignment out of the ROK.	1	2	3	4	5
Commanders respect patient confidentiality when it comes to BH issues.	1	2	3	4	5
There are sufficient BH assests in the ROK.	1	2	3	4	5

F. Personal Well-being

49. Overall, in the **PAST MONTH**, how would you rate your health?

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

50. How often in the **PAST MONTH** have you gone to sick call or visited a doctor or other medical professional for a physical condition?

0. Zero times
1. One time
2. Two times
3. Three or Four Times
4. Five or More Times

51. The following questions ask about how you have been feeling during the **past 30 days**. For each question, please select the response that best describes how often you had this feeling.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
...tired out for no good reason?	1	2	3	4	5
...nervous?	1	2	3	4	5
...so nervous that nothing could calm you down?	1	2	3	4	5
...hopeless?	1	2	3	4	5
...restless or fidgety?	1	2	3	4	5
...so restless that you could not sit still?	1	2	3	4	5
...depressed?	1	2	3	4	5
...so depressed that nothing could cheer you up?	1	2	3	4	5
...that everything was an effort?	1	2	3	4	5
...worthless?	1	2	3	4	5

52. Rate the following:

	VERY LOW	LOW	MEDIUM	HIGH	VERY HIGH
Your personal morale	1	2	3	4	5
Your BH team morale	1	2	3	4	5

53. On average, how many hours of sleep do you get per day?

1. 3 or fewer
2. 4
3. 5
4. 6
5. 7
6. 8 or more

54. Please rate your sleep pattern for the past 2 weeks.

	NONE	MILD	MODER-ATE	SEVERE	VERY SEVERE
Difficulty falling asleep	1	2	3	4	5
Difficulty staying asleep	1	2	3	4	5
Problems waking up too early	1	2	3	4	5

55. How **SATISFIED/DISSATISFIED** are you with your **CURRENT** sleep pattern?

1. Very satisfied
2. Satisfied
3. Moderately satisfied
4. Dissatisfied
5. Very dissatisfied

56. How **NOTICEABLE** to others do you think your sleep pattern is in terms of impairing the quality of your life?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

57. How **WORRIED/DISTRESSED** are you about your current sleep pattern?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

58. To what extent do you consider your sleep pattern to **INTERFERE** with your daily functioning (such as daytime fatigue, mood, ability to function at work/daily chores, concdntration, memory, etc.)?

1. Not at all
2. A little
3. Somewhat
4. Much
5. Very much

59. What can be done to help BH staff function more effectively?

_____

_____

_____

THANK YOU FOR COMPLETING THIS SURVEY

15 APPENDIX C: SOLDIER FOCUS GROUP QUESTIONS

1. **Quality of Life**

- What are your biggest challenges here in Korea?
  - Barracks
  - DFAC
  - KATUSA interactions
  - Policies specific to Korea (e.g. curfew, alcohol)

2. **Transitions**

- Thinking back to when you arrived Korea, how did your transition go?
- Is Korea / your unit what you expected?
- What was the hardest part of your transition?
- How could future Soldiers be better prepared for being stationed in Korea?

3. **The Mission**

- Do you feel your mission is clear and do you think it's important?

4. **Unit Climate: Morale and Leadership**

- How is the morale in your unit?
- What things help morale?
- What hurts moral?
- (NCOs only)
  - What are key skills of being a successful leader in Korea?
  - Are these skills different for leaders in CONUS?

5. **Social Relationships**

- What types of things help you stay connected with your friends and family back home?
- What about within Korea?
- Is there anything that makes it difficult here in Korea or specifically within your unit?

6. **Alcohol**

- What contributes to alcohol-related problems here in the ROK?
- What can the command do better to help Soldiers prevent alcohol-related incidents?
- What are your thoughts about ASAP?

- What can be done to help this program be more effective?

7. Behavioral health access to care and support

- What are most Soldiers attitudes towards seeking behavioral health services in Korea?
- Have you ever urged or helped another Soldier get behavioral health help in Korea?
- What would be the point where you would recommend to a battle buddy to seek help rather than just taking care of things themselves?
- What are the biggest obstacles for Soldiers seeking out behavioral health support (e.g. concern about confidentiality, resources available, time, don't like the provider)?
- What types of things can leaders do to encourage people to seek help when they need it?

8. Suicide

- How much do you think suicide is an issue here?
- What are the risk factors for suicide in Korea?
- Is suicide training effective in preparing you for handling a suicide event? What could be improved?
- Is there anything Leadership can do better to help prevent suicides?

9. Coping

- How do you deal/manage with stress?

16 APPENDIX D: BEHAVIORAL HEALTH PROVIDER FOCUS GROUP QUESTIONS

1. **General Korea Behavioral Health Support**

   - What are the most common problems Service Members are seeking care for in Korea?
   - Are there any issues you see here in Korea that are unique compared to other locations?

2. **Suicide-related Issues**

   - How many Service Members have you seen for suicidal ideation during this tour? Is it what you would expected?
   - What are the drivers of suicidal ideation/behaviors that you see? Is anything unique to being stationed in Korea?
   - Describe the suicide prevention program in your area of responsibility?
   - How effective do you think that program is?
   - What tools/training would make for a more effective suicide prevention program?
   - How effective do you think the current suicide prevention training is?

3. **Alcohol and Substance Use**

   - How many Service Members have you seen for alcohol or substance abuse problems? Is it what you would expected?
   - What are the drivers of alcohol/substance abuse problems that you see? Is anything unique to being stationed in Korea?
   - Describe the Alcohol and Substance Abuse Prevention program in your area of responsibility?
   - How effective do you think that program is?
   - What tools/training would make for a more effective ASAP?
   - How effective do you think the alcohol/substance misuse prevention training is?
   - Is there anything that the Command can do to lessen alcohol-related behaviors?

4. **Return to Duty**

   - What kinds of questions come up for you as a provider when you are making return to duty decisions (RTD) surrounding behavioral health issues?
   - What are the hard RTD questions pertaining to psychological health?
   - How much training have you been provided to make RTD decisions? Is it enough?
   - How much is risk aversion affecting decisions to return Service Members to duty (for providers and for leadership)?

5. **Resources**

- How much is staff turnover a problem? Why or why not? What can be done to help?
- Is it difficult to provide behavioral health support to everyone in your catchment area? Why or why not?
- Do you have adequate office space and equipment (computers, etc.)?
- What additional resources would you like to have to enable you to do your job better?
- What logistical challenges exist in reaching personnel in outlying areas? Have you tried to do to remedy these challenges? If so, how?
- What are the core responsibilities of the 68Xs here? Is their training adequate? Do they do therapy?
- What other responsibilities could 68Xs take on?

6. **Treatment: Engagement, Adherence, and Adaption**

- What types of things do you do to ensure treatment engagement and adherence?
- How much is behavioral healthcare drop out a concern for you? What can be done to remedy drop out?
- What adjustments have been made to accommodate specific issues here in Korea in support of treatment adherence?
- What suggestions do you have to encourage Soldiers to get mental healthcare if they need it (e.g. overcoming stigma/barriers to care)?
- What suggestions do have for improving the mental health literacy of Service Members (e.g. knowing resources, rules about confidentiality, command relationship)?
- Which behavioral health Treatment Best Practices are you using and how have you adapted them for working in Korea?
- Were you trained to do this or did you have to come up with it on your own?

7. **Working Behavioral Health Mission with Others**

- How often do you interact with other behavioral health Providers? What occurs during those interactions? Is it helpful?
- How do you interact with Chaplains/Chaplain assistants?
- How do you interact with Medical Providers regarding behavioral health issues (e.g. prescriptions coordinated between providers)?
- What are the standardized events that include both medical and behavioral health staff?

8. **behavioral health Provider Well-Being**

- How would you describe your personal morale?
- Is your ability to do your job being impaired due to stressors associated with being forward-positioned in Korea?

- In terms of your personal experience, how is it different doing therapy in this environment compared to CONUS garrison (for those who have been other CONUS locations)?
- Is it more rewarding and/or more difficult? Why?
- How much has burnout been an issue for behavioral health providers during your tour in Korea?
- What types of things contribute to burnout (e.g. location, amount of travel, type of patient, patient load, command climate)?
- What's being done to keep behavioral health providers from becoming burned out?

9. Command Relationships

- How is your relationship/communication with the unit leadership you support?
- What challenges have you faced in working with leadership?
- Do Commanders need more education about how to access behavioral health services for their Service Members?
- Do they need more education about the confidentiality of behavioral health information?
- Are there any other issues with Command that could improve behavioral healthcare for Service Members?

10. Tele-behavioral Health

- Is Tele-behavioral Health (TBH) available in your area? In areas you support?
- Are you providing behavioral healthcare via TBH? If so, how is it working?
- Is TBH and backfill support in ROK Soldiers adequate to augment your workload?
- Are Soldiers receptive to receiving TBH? What do they like or not like about it?
- How do BH Providers feel about providing TBH?
- Are there challenges to using TBH? If so, what are they?

11. Final Thoughts

- Are there any issues/considerations that have not been addressed that you would like the MHAT team to be aware of here in Korea?